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**MULTIPLE CASE STUDIES EXPLORING INTEGRATION OF SPIRITUALITY IN
UNDERGRADUATE NURSING EDUCATION IN ENGLAND**

GULNAR ALI

A THESIS SUBMITTED TO THE UNIVERSITY OF HUDDERSFIELD IN PARTIAL FULFILMENT OF
THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

THE UNIVERSITY OF HUDDERSFIELD

SEPTEMBER 2017

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Last but not the least I want to thank my daughters Sara, Sarosh and Sofi, parents Mr. Gulamali Virani and Mrs. Laila and sisters, Ms. Gulzar and Dr. Gulnaz for their unconditional love and wisdom that made me stronger and resilient enough to face all the ups and downs in my personal and professional life. During my study years, I was away from my parents and sisters physically, nevertheless, they were always there as a beacon of hope and courage for me and my children.

I see my PhD journey as an opportunity for intellectual and emotional metamorphosis; a transformational phase of my life that enabled me to find my own self, my aspirations and meaning in life. It is my deep conviction that nothing is impossible in life, if one realises the inner quest and dares to face one's own fears!

Thank you all for empowering me with knowledge and courage to become what I always wanted to be!

Abstract

Introduction

Difficulties persist in conceptualising spiritual needs and understanding their relationship to religious needs and wellbeing in healthcare and particularly in nursing education. This research was undertaken to explore approaches and challenges associated with this area in undergraduate nursing education in England.

Methods/Methodology:

Using a systematic approach, a literature review covering the period 1993-2017 was undertaken to explore potential issues and challenges reported.

Applying case-study methodology, data were collected from three university nursing schools from different parts of England. Sources for data triangulation within schools included, curriculum review of undergraduate nursing courses, exploring the views of nursing educators through semi structured interviews and focus group studies with nursing students. Template analysis was used to identify themes in the data.

Findings:

Due to the module based curriculum, the integration of spirituality in nursing education appeared to be treated as a matter of personal choice and convenience rather than as an essential domain of teaching and learning practice in England. Owing to conceptual complexity, addressing religious needs was often considered to be synonymous with addressing spiritual care need. Factors were identified contributing to the difficulties in the issue of educating nurses in this area. These were: lack of clarity in curriculum documents; uncertainty as to how far nurses should address these issues and how far this was a specialist chaplaincy function; fear of being judged or rejected in a multicultural environment; and the dominance of disease-centred care. The participants voiced a desire for developing a shared understanding through developing a more explicit representation of spirituality in nursing education and the recognition of appropriate educational approaches in this area. Based on the findings of this study a learning framework is proposed; SOPHIE (Self-exploration through Ontological, Phenomenological, Humanistic, Ideological, and Existential expressions), to encourage self-awareness and reflexivity among nursing educators and students. SOPHIE aims to bring ontological authenticity and congruency to the forefront of nursing knowledge and practice.

Conclusion:

Constructing knowledge through ontological learning engagements among educators and students is essential to develop role clarity, authenticity and empowerment in understanding and addressing spiritual care needs. A multidisciplinary teaching approach integrating medical anthropology, humanistic psychology and existential phenomenology should be explored as a basis for an integrated nursing curriculum that could explore spirituality in its widest sense.

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List of Abbreviations

AACN (American Association of Colleges of Nursing)

AEIs (Approved Educational Institutions)

ASSET (Actioning Spirituality and Spiritual Care Education and Training)

BERA (British Educational Research Association)

CASP (Critical Appraisal Skills Programme)

CSCT (Communicating for Spiritual Care Test)

DSES (Daily Spiritual Experience Scale)

EWB (Existential well-being)

ICN (International Council of Nurses)

IJAS (International Journal of Arts and Sciences)

NANDA (The North American Nursing Diagnosis Association)

NHS (National Health Service)

NMC (Nursing and Midwifery Council)

nnp (no page number)

RCN (Royal College of Nursing)

RRES (Revised Response Empathy Scale)

RWB (Religious well-being)

SCCS (Spiritual Care Competence Scale)

SCERP (Spiritual Care Educational and Reflective Program)

SCI (The Spiritual Care Inventory)

SCGS (Spiritual Care-Giving Scale)

SCPS (Spiritual Care Perspective Scale)

SCPSR (Spiritual Care Perspective Scale-Revised)

SOPHIE (Self-exploration through Ontological, Phenomenological, Humanistic, Ideological, and Existential expressions)

SSCRS (Spirituality and Spiritual Care Rating Scale)

STAT (Spirituality Textbook Analysis Tool)

SREP (School Research Ethics Panel)

SWBS (Spiritual Well Being Scale)

TRUST (Traditions, Reconciliation, Understandings, Searching, and Teachers)

WHO (World Health Organization)

WHO-QOL-SRPB (World Health Organization Quality of Life-Spirituality, Religiosity
and Personal Belief)

Academic Biography

Personal Statement

I have a particular interest in the ontological aspects of human phenomenon and a strong commitment to a caring approach that facilitates human development. My professional background covers a wide spectrum of teaching and research experience in Nursing, Mental health, Health and Social Care, Moral Philosophy and Management.

Education and Qualifications

PhD Candidate-Exploring the integration of Spiritual and Existential care aspects in Nursing

Education (2013-2017).

School of Human and Health Sciences, University of Huddersfield, UK

Research Design: Multiple Case Studies across England

MSc. Medical Anthropology (2006-2007)

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Subjects Studied: Advanced Social and Cultural Issues, Psychology and Medicine, Anthropology of Psychiatry, Gender and Sexuality, Anthropology of Religion.

MA Islamic Studies (2000-2002)

University of Karachi, Pakistan

Subjects Studied: Quranic Studies, Education, Sociology, and Philosophy.

BA Islamic History-(1997-1999)

University of Karachi, Pakistan

Subjects Studied: History, Education, Sociology, and Philosophy.

Diploma in Nursing - (1995-1998)

The Aga Khan University Hospital, School of Nursing, Pakistan

Subjects Studied: Nursing Studies, Community Development, Mental Health, and Ethics.

Oral presentations and Publications

Some of my scholarly endeavors including international conference presentations and indexed publications are listed below:

Research Presentation: International Conferences and Seminars

- | | |
|----------------|--|
| 22 May, 2017 | Abstract submitted on, SOPHIE (Self-Exploration Through Ontological, Phenomenological, Humanistic, Ideological, And Existential Expressions SOPHIE)-A Teaching And Learning Framework For Approaching Spiritual Care Needs In Nursing Education . Spirituality Scholars' network 1st International Symposium, an initiative of the British Association for the Study of Spirituality (BASS), to be held at the University of Huddersfield, UK on July 10, 2017. |
| 23 Feb, 2017 | Proposing Ontological Learning Approaches To Transform Health Education . Nursing Steering Committee at University of East London, UK. |
| 26 Jan, 2017 | Approaching Spirituality in Health Education . Oral presentation at the Institute for Health and Human Development, University of East London, UK. |
| 27 April, 2016 | Mental health and Spirituality- Workshop for carers, Aga Khan social welfare board, London. |
| 10 Mar, 2016 | PhD research findings on, Issues and Challenges in Approaching Spirituality in Nursing Education across England . Spirituality interest group, University of Huddersfield, UK. |

3-6 Nov, 2015

Presentation on, **Exploring Issues in Relating Spiritual Care Aspects in Nursing Education** at, IJAS international conference, London, UK.

Publications:

Book Chapter:

Snowden, M & Ali, G. (2017). How Can Spirituality be Integrated in undergraduate and Postgraduate Education. In J. Wattis, S. Curran & M. Rogers (Ed.), *Spiritually Competent Practice in Health Care*. (In Press)

Publications in Indexed Journals:

Ali, G., Wattis, J., Snowden, M. (2015). Integrating spirituality in Nursing Education, *International Journal of Multidisciplinary Comparative Studies*, Vol 2 No.1, 2015, pp.7-31, London.

Chapter One: Background and Context

1.1 Introduction

This chapter explores my personal quest and professional aspirations as a background to embarking on this doctoral project. It includes an overview of how spirituality is approached in health care in general and particularly in nursing philosophy and practice. This chapter identifies the importance of integrating spirituality in nursing education. After establishing the background and context of this study, I present an overview of this study with the specific aims and objectives. Finally, a brief synopsis on each chapter is presented here, providing an overview of the thesis structure.

1.2 Personal and Professional quest

Being a mental health nurse with a background in humanities, I was always keen to understand the human phenomenon from the perspective of health care provision. Particularly with reference to nursing, my quest was to understand how spiritual aspects of human development were approached in practice and addressed through nursing education. My academic background includes qualifications in Islamic Studies, Islamic History, Medical Anthropology and Nursing. Moreover, I have been involved in various teaching and research activities over the last 18 years.

With hands on clinical experience in acute mental health and rehabilitation management, my professional expertise includes working with learning disability children, elderly patients with dementia and forensic mental health care, both in London and Pakistan. From 2010-12, I was involved in teaching at The Aga Khan University School of Nursing, Pakistan, focusing on the transcultural and humanistic aspects of human development. As a Senior Instructor, I was engaged in developing the curriculum for undergraduate nursing programmes in Pakistan along with my research and publication activities both at national and international levels.

Through my experience, I developed a conviction that, alongside technical aspects of care and treatment, intangible aspects of human experience such as hope and meaning influenced health outcomes. I began to observe my clients particularly for these aspects of experience and observed that although life is full of uncertainty the human mind finds it hard to accept some changes, especially loss and suffering. Whether individuals successfully cope with a stressful situation depends

not only on physical factors but also on their own perceptions, beliefs and value systems. To me, the phenomenon of healing appeared to embrace not only physical, mental and social processes of recovery, repair, renewal and transformation but also a spiritual dimension related to meaning and hope. Taken together these processes could be seen as leading to increased wholeness. However, as a nurse, I found myself inadequately prepared with the competencies necessary to promote and support this holistic healing. This insight inspired my quest to learn more about values and belief systems and their relevance to holistic nursing. Therefore, I pursued an MA in Islamic Studies to inquire about how religion influences resilience and coping. Nevertheless, the question remained unresolved and led me to undertake an MSc programme in Medical Anthropology, to inquire more about the influence of beliefs on mind-body interaction and the phenomenology of healing. Along with varied professional experiences both in clinical and community set ups, my academic interest continued and I decided to translate my quest into a PhD research project. With a vision to expand the notion of care, I aimed to explore the challenges in nursing education that limit the integration of spiritual and existential aspects of care in favour of a disease-centred model of care.

1.3 Conceptual Framework

The underlying concepts, beliefs, personal assumptions and philosophical perspectives that guides the research constitutes a conceptual framework (Robson & McCartan, 2016). It is important to explain the philosophical position of the researcher behind the aims and aspiration of the study. This enables the researcher to establish the context, aim and rationale for choosing a particular methodology by explaining its epistemological and ontological basis to the readers (Mason, 2002; King & Brooks, 2017). Moreover, it is important to acknowledge the researcher's philosophical understanding, belief patterns and intellectual values that had contributed towards the researcher's aspirations to take a step forward towards new knowledge construction through research (Willig, 2008; King & Brooks, 2017).

1.3.1 Epistemological and ontological position

Epistemology is the underlying theory of knowledge and underpins the researcher's knowledge-seeking approach and underlying assumptions about how knowledge can be obtained. Ontology relates to the researcher's philosophical assumptions about reality including reference to self-knowledge about being and existence (King & Brooks, 2017). Qualitative researchers are expected to be reflexive and record reflections to establish credibility, quality and rigour at different stages throughout the research. Reflexivity also enhances critical thinking and the creativity of the researcher in achieving robust research findings (Langdridge, 2007; King & Brooks, 2017). The epistemological and ontological basis for selecting an appropriate research methodology and design for this study is discussed in Chapter Three. A detailed account on how validity and reliability was established during data collection and analysis is presented in Chapter Four. Rigorous data analysis, including triangulation within cases and comparison between cases was combined with the findings from the literature review (Yin, 2009; 2014). This revealed knowledge and practice gaps in undergraduate nursing education. Hence, a teaching and learning framework to address spiritual care needs, SOPHIE was developed as a research output. However, personal assumptions influence the data analysis and findings and this could result in unconscious bias (Robson & McCartan, 2016). To aid transparency a reflexive account based on my entire research journey and my engagement with the inquiry and meaning-making process during data analysis is presented in Chapter Twelve. As discussed in section 1.2, an academic and professional background in Islamic studies, medical anthropology, philosophy and mental health nursing, resulted in a quest to understand how spirituality was approached in nursing education. The following sections explain how my understanding of spirituality has been developed on the basis of Islamic philosophy, existential phenomenology and nursing ontology.

1.3.1.1 Notions of Spirituality in Muslim traditions of thought

A brief explanation on relating spirituality to intellectual thought in Islam is presented below to share how my views and beliefs may have influenced the conceptual understanding and inquiry approach to this study.

The concept of God is understood as an ultimate ideal and source of spirituality reflected in all aspect of human life in all Judaic, Christian and Islamic traditions (Esmail, 1998). According to Islamic thought, religious experiences such as striving to seek wisdom, self-consciousness, and humility are multiple expressions of actualising spirituality (Walker, Simonowitz, Poona Wala, Callataÿ 2016). In Islamic traditions, religion itself is considered as a way of life and principles of faith guide the human intellect in every facet of life. In Islam, in contrast to Western secular thinking, there is no dichotomy between faith and intellect or between sacred and secular aspects of human life (Keeler & Rizvi, 2016).

For Muslims self-consciousness and God-consciousness guides pious conduct in individual and communal life. Several Muslim poets and philosophers have related the existential and intellectual capabilities of the human mind to explain mystical experiences of self-recognition (Madelung & Mayer, 2015; Walker et al., 2016). A few philosophical interpretations focusing on the meaning of self-awareness, personal search and spiritual quest in Muslim traditions of thoughts; are discussed below.

Walker et al., (2016) discuss intellectual traditions in Islam and assert that, according to Shi'i philosophical traditions, the power of thought realised through pure intellect enables spiritual growth and wisdom. The notion of thought and knowledge is often associated with the concept of revelation, which is often rooted in a religious doctrine. The concepts of revelation in a Muslim context, have also been related to philosophy, based on Aristotelian thought about *nous* (intellect) and Neoplatonic ideas on knowledge seeking. Neoplatonism was a philosophical movement, founded by Plotinus (205-270 CE), that explored metaphysical ideas about being, absolute intellect and related them to eternity (El-Bizri, 2006).

Walker et al., (2016) further explain that, the positions of the human intellect has been situated as a central theme linking the spiritual connection between microcosm and macrocosm, the inner and outer world of a human within and beyond time and space. Human intellect is defined as a faculty of soul and spirit, that has transcendent power to ascend towards timelessness and realise it self. Ibn-Arbi' (1165 CE-1240 CE) a mystic and a Muslim philosopher explored the nature of existence. The Arabic word *Wajud* has been used in Ibn-Arbi's work to expand the meaning of existence and its potential for growth in searching for its relationship with ultimate reality. According to Ibn Al-Arbi,

human knowledge and experience form religious consciousness, which relates to spirituality. Ibn Sina (980-1037 CE), also known as Avicenna, offers esoteric insights into the Muslim intellectual legacy based on Aristotelian philosophy. He uses a variety of intellectual genres including mythopoeic texts to portray the quest of the human soul with an aesthetic impact and define the esoteric nature of the soul that longs for salvation. Ibn Sina relates Aristotelian metaphysics and contributes to establishing a philosophical basis of Neoplatonism in Muslim history by explaining human cognition, reasoning and its relationship with the supreme intellect, the Divine. His work *Kitab-al Shifa*, (*book of healing*), is considered a significant contribution in defining ontological and epistemological influences shaping human perception and sets of behaviours as a result of using intellect to search the ultimate purpose of life (Shefer-Mossensohn, 2009; Madelung et al., 2015).

Esmail (1992, 1995 and 1998), a contemporary Muslim philosopher, compares the intellectual traditions of Islam with the history of thought from Western philosophy. Esmail analyses the meaning and articulation of the sacred in its social context. He distinguishes theological doctrine from religious experiences and defines religion as a vision, which influences human intellect, imagination, perception, conviction, emotion and behaviour. According to Esmail, religion appears both implicit and explicit in human life defining cultural values, language development, intellectual progress, social interactions and symbolic interpretations in searching and encountering the sacred.

Hence, according to Muslim philosophy, the search for an ultimate reality or the divine be pursued in various ways. The Islamic perspective allows a variety of interpretations and traditions within and outside of Muslim civilizations. Moreover, throughout various intellectual traditions of Islam, a major emphasis is placed on the notion of personal search and self-awareness to recognise the spiritual aspect of religious life (Esmail, 1998; Madelung et al., 2015).

1.3.1.2 Existential phenomenology and spirituality

Existential phenomenology is an approach to understand one's own self and the world around by describing experiences and understanding the meaning of existence (Stewart & Mickunas, 1974; Zahourek, 2005). Ontology is concerned with being and ontological explanations describe the position of self with reference to human existence and in relation to others in society (Green, 2005). Also, ontological perspectives explore the influence of thinking, perception and intentionality on human

actions. From the phenomenological perspective, a purposeful mental act has been defined as intentionality (May, 1969; Searle, 1995; Zahourek, 2005). Intentionality has been referred to as the essence of consciousness: "*our imaginative participation...out of which comes the awareness of our capacity to form, to mould, to change ourselves...in relation to each other...intentionality is at the heart of consciousness*" (May, 1969; p. 223).

Existential phenomenology affirms that each individual has unique inner resources which may guide caregivers in planning person- specific therapeutic care in order to assure compliance and recovery of mentally ill clients (Moore and Goldner-Vukov, 2009). With reference to holistic care, it is existential awareness through which a person finds the meaning in being ill or well. In addition, it is the personal existential state that defines the person's connection with interacting environmental forces and society (Blaikie & Kelson, 1979; Jones, 2006). As, Merleau-Ponty explains,

The life of consciousness-cognitive life, the life of desire or perceptual life- is subtended by an "intentional arc", which projects round about us our past, our future, our human settings, our physical, ideological and moral situation, or rather which results from our being situated in all these respects. It is this intentional arc which brings about the unity of the senses, of intelligence, of sensibility and motility. And it is this which "goes limp" in illness (Cited in Baldwin, 2004, p. 17).

1.3.1.3 Nursing philosophy and Spirituality

Nursing philosophy revolves around the ethos of person-centred, spiritual and existential aspects of human development. Contemporary nursing scholars, including Benner (1994), Parse (1998), Newman (1999), McSherry and Jamieson (2011) and Benner, Sutphen, Leonard, and Day (2010) emphasise this foundation as a means of enabling personal transformation and promoting healing holistically. McSherry (2006, p. 917) asserts that, "*spiritual care permeates and integrates all aspects of care provision just as spirituality integrates and unites all dimensions of the individual*".

Nurturing and transforming nursing approaches can accelerate the development of increased self-awareness in patients by expanding their subjective consciousness, facilitating transcendence at an intuitive level (Newman, 1999). Newman's (1997) theory of Health as an Expanding Consciousness provides an ontological paradigm to plan nursing care on intentionality grounds. According to

Newman's (1997, 1999) theory disease is a manifestation of an underlying imbalance within a patient. Health is more than the absence of disease; health is the expansion of consciousness, or personal growth. From this perspective, even an episode of ill health can transform a patient's life into a higher state of being, or consciousness, which could also be described as spiritual growth. Newman (1999) asserts that, it is the intentional and meaningful engagement of a nurse with a patient and family or community, where the focus of nursing care shifts from symptomatic care to recognising the patterns of thinking beyond those symptoms. Intentionality has been identified as an essential component of the subjective reality of self and contributes to the philosophical foundations of person-centred care in nursing (Flaming, 2004). Fundamental to spiritual and existential aspects of human life, intentionality may affect personal resilience as a response to illness, modifying the course of the illness (Rogers, 2016). Illness, loss, or disability may challenge a person's understanding of the meaning and purpose of their lives and they may require support in readjusting their understanding and life goals. A spiritually competent nurse may recognise these challenges and help people regain hope and meaning in life. Many robust studies have shown that spirituality is fundamental for patients in helping them regain hope, meaning and purpose in the midst of illness (Koenig, 2004, 2014; Rogers & Wattis, 2015). Thus, the nurse in partnership with the patient and family explores the potential for growth and changes needed to bring transformation in attitude towards life. With reference to nursing care, spirituality has always been considered as an influential resource facilitating healing and resilience (Newman, 1995; Parse, 1998; Flaming, 2004; Rogers, 2016). As Swinton (2001) explains:

While the human spirit may be deeply mysterious, pointing as it does towards aspects of reality that are deep, unfathomable and transcendent, spirituality is a human activity that attempts to express these profound experiences in inner longing in terms that are meaningful for the individual (Swinton, 2001, p. 21).

According to Swinton (2001), spirituality could be a deep and mysterious concept however, it influences human thought and behaviour formation towards life. A detailed conceptual analysis on spirituality in health care is presented in Chapter Two. In the following section, I will discuss why integrating spirituality is essential in health care to signify its relation to nursing education and the importance of this research.

1.4 Issues in focus

Health is more than the absence of disease and has been approached as the expansion of consciousness, personal growth and self-awareness (Newman, 1997, 1999). Health and wellbeing are affected by several variable factors, which include bio-physiological, psycho-social and religio-political contexts (Eisenberg & Kleinman, 1981; Littlewood & Dein, 2000; James & Hockey, 2007). But the biomedical approach seems to focus primarily on validating the client's objective data only, rather than seeking to unfold the underlying subjective complexities of interpersonal relationships often in a multi-cultural context. This debate is grounded in the Cartesian understanding of the dichotomous nature of the human phenomenon (Wattis et al., 2017). The role of human agency and the power of self-awareness, positive intentionality, consciousness and creativity have been considered active agents in humanistic therapeutic approaches to the subjective phenomenological interpretations of wellbeing. However, these forces have often been reported as 'unrecognised in nursing' (Whitehead, 2003, p.1). Care giving practices are still often grounded in biomedical models and interpersonal, existential and spiritual care aspects remain neglected (Daaleman et al., 2001). Holistic nursing care recognises the importance of spiritual and religious care in promoting health and wellbeing (RCN, 2011; NANDA, 2014; RCN, 2015). However, acceptance of the authentic self of a patient often remains missing in nursing care (Daaleman et al., 2001). Nursing standards (NMC, 2010), mention the need to include spiritual assessment in nursing education and practice. McSherry and Jamieson (2013) reported a UK survey of nurses' perceptions of spirituality and spiritual care with 4054 respondents conducted in 2010. They found that nurses struggled to conceptualise spirituality even though they recognised it as an important aspect of holistic care. They emphasised the need for more training in this area and for training to be related to practice. Including spirituality within the nursing curriculum is an important way of ensuring nurses have the opportunity to explore what spirituality is and how to address it in practice. Prentis et al., (2014) conducted a small survey of University teachers including nursing educators with qualitative and quantitative elements. Whilst most agreed that spiritual issues were relevant in the education of health professionals only 17% reported that spirituality was covered in their teaching practice and curricula. They identified a number of obstacles and facilitators to education about spirituality. In this context, it is vitally important to explore students' perceptions and needs in this area and to identify how the curriculum can prepare students to nurse with spiritual competency.

Denying the authentic, valuable, personal unique self and disregarding the philosophical concepts underlying intentionality and personal experiences, alters the therapeutic regimen significantly. Recovery, defined holistically, remains a challenge in providing quality care (Whitehead, 2003). Nursing assessment and care planning do not always take these factors into account; neither are the spiritual aspects of care always made explicit in standards. Though formal recording of religious affiliation is commonly undertaken, the assessment of spiritual needs is rarely recorded. Although, in the UK, the Nursing and Midwifery Council's Code (NMC, 2015) recognises the importance of person-centred care, it contains no explicit mention of spiritual need. In practice, patients' spiritual care appears to have been neglected (Daaleman et al., 2001). This may be related to its relative neglect in nurse education illustrated over the past three decades by writers such as (Narayanasamy, 1993; McSherry & Draper, 1997; Ross et al., 2014; Kalkim et al., 2016).

Over the last two decades there has been a series of calls to integrate spiritual care into nursing education and practice by developing relevant standards and learning outcomes in nursing education (Narayanasamy, 1999a; Benner et al., 2010; McSherry & Jamieson, 2011; Ross et al., 2014). Nursing care often seems to lack spiritual and existential perspectives (Berg & Sarvimaki, 2003; Whitehead, 2003). Whitehead (2003) questions whether existing nursing education prepares nurses to assess and recognise a person's existential health status and to plan care accordingly. Furthermore, Francis (2013) in the Mid-Staffordshire Hospital Inquiry Report described a culture in which nurses and other clinicians failed to recognise the human needs of patients, including aspects of person-centred care. This reflects a significant failure in addressing these needs within the provision of health and social care and in the education of healthcare professionals.

1.5 Importance of this research study

The present study aims to explore the reasons behind this failure by examining what happens in real-life learning situations for student nurses and educators where integrating spirituality is reported to be a challenge (Ross et al., 2014; Kalkim et al., 2016).

This study contributes to understanding how spirituality is approached in undergraduate nurse education. By conducting a literature review from (1993-2017) combined with exploratory multiple case studies at different universities across England, this study investigates the needs and existing

challenges faced by nursing students and educators in relating spirituality to nursing education. Also, undergraduate nursing curricula and related documents used in each case are examined to explore how curriculum requirements are delivered and whether they facilitate developing competency in addressing spiritual need.

1.5.1 Research aim and objectives

The following were the aims and objectives of the research study.

Aim:

This study aimed to contribute to a better understanding of how nursing competencies in understanding and addressing spiritual needs are currently approached in undergraduate nurse education, in England. On the basis of this improved understanding it was hoped it might be possible to propose ways of further developing education in this area to address patient need in a more holistic way.

Objectives:

1. To examine the course curriculum and related documents for undergraduate nurse education in a number of schools of nursing, across England.
2. To determine the views of key nurse educators in those schools about how teaching on spiritual care is delivered and how it might be improved.
3. To determine how teaching on spiritual care is perceived by students in those schools in England and how they think it might be improved.
4. To understand and synthesise these findings in a way that might contribute to developing education in this area further.

1.6 Overview of thesis Structure

This thesis is organised in twelve chapters:

Chapter One presents the study context and personal and professional aspirations behind this research. It provides an over view of the study and describes the thesis structure.

Chapter Two presents the conceptual analysis of the term spirituality from multiple health care perspectives. After establishing the rationale and context of the study, Chapter Two discusses the

literature review from 1993-2017. A critical appraisal of relevant studies conducted across the world, with a brief discussion on the findings based on the literature review is provided in this chapter.

Chapter Three reviews different qualitative methodologies considered and explains why they were discarded in favour of a case study approach. It also relates the research question, aims and objectives of this study to the multiple case study design and provides the rationale for considering it the most appropriate approach for this study.

Chapter Four discusses the research methods used to assure the quality and credibility of this study. From seeking ethics approval to enrolling universities to collecting data, there were many challenges that could have affected the validity and timely completion of this study. Despite all the challenges, quality control measures were taken at each step. A detailed account of strategies taken to address each challenge during data collection will be presented in this chapter. Chapter Four elaborates upon the process of data analysis using Yin's (2009) multiple case study analysis techniques with template analysis (Brooks & King, 2014; King & Brooks, 2017). Three complete case studies (labelled A, B, C) were analysed. Partial data were also collected on two other cases (labelled D, E) but did not form part of the main analysis.

Chapter Five presents the data collected from case study A. A detailed case report is presented through themes and sub-themes using case study design and template analysis.

Chapter Six presents the data collected from case study B. A detailed case report is presented through themes and sub-themes using case study design and template analysis.

Chapter Seven presents the data collected from case study C. A detailed case report is presented through themes and sub-themes using case study design and template analysis.

Chapter Eight presents the data collected from (partial) Case study D. It identifies specific issues and limitations faced during data collection. Consequently, case four presented incomplete data sets, insufficient for data triangulation. This case study was not used for data analysis.

Chapter Nine presents the data collected from (partial) Case study E. It identifies specific issues and limitations faced during data collection. Consequently, case five presented incomplete data sets, insufficient for data triangulation. This case study was not used for data analysis.

Chapter Ten presents findings that emerged from cross-case synthesis and presents the data analysis as themes and sub-themes. It compares and analyses the data across all three case studies (A, B, C), for literal and theoretical replication.

Chapter Eleven summarises the research findings and combines it with the literature review to explore the nature of underlying gaps in nursing education. By presenting a critique based on the research findings, the chapter recognises several challenges and points out the deficiencies that are affecting nursing education. Also, this chapter introduces and elaborates upon SOPHIE, which is based on the findings and is proposed as an innovative teaching and learning framework for spiritual care in nursing education.

Chapter Twelve is on reflexivity. This chapter explains that how quality control measures were used throughout the research, to assure the credibility of the study findings and data analysis. By providing evidence as personal memos and diary entries, chapter twelve presents the entire process of reflexivity which involved peer validation and feedback from wider academia, to minimise any personal biases.

Chapter Thirteen concludes the thesis. By summarising key findings, it identifies possible pathways to transform nursing education based on the identified issues. It discusses limitations of the study and highlights dissemination strategies and future research prospects based on the study outcomes. A reflective account upon the experience of conducting the study and the personal and professional growth based on it concludes the thesis.

1.7 Chapter Summary

In this chapter, I have reflected upon the personal beliefs and professional experiences that inspired me to explore more about spirituality in nursing. I have discussed my personal transformation in terms of my academic journey and how my hopes and beliefs were shaped, reshaped and inspired by undertaking this project. In addition, I have explored that how spirituality anchors nursing philosophy. After recognising existing challenges in nursing care to establish the context of the study, this chapter has described the need and scope of the research. A brief over view of each chapter in the thesis has also been presented.

Chapter Two: Literature review

2.1 Introduction

This chapter initially presents a conceptual analysis of the term spirituality from a healthcare perspective. After establishing the context of this study, a systematic literature review 1993-2017, is presented. The literature review identifies current knowledge about the development of competencies to assess and address patients' spiritual care needs in undergraduate nursing education. Chapter Two also presents underlying knowledge and practice gaps in undergraduate nursing education, establishing the rationale for this research project.

2.2 Concept of Spirituality in health care

Spirituality has been approached from a variety of perspectives in healthcare acknowledging its social, cultural, religious, political, linguistic, humanistic and phenomenological aspects (McSherry & Draper, 1997; McSherry & Cash, 2004). The plethora of meanings and different associations of the term spirituality for different people generates confusion and lack of clarity among health care professionals (Kalkim et al., 2016; Wattis et al., 2017). This, in turn, leads to problems in incorporating spirituality into education and practice (Greenstreet, 1990; Caldeira et al., 2016). Some associated concepts that are widely used in understanding spirituality in health care, are discussed below.

2.2.1 Religion and Spirituality in health care

Spirituality is often regarded as synonymous with the institution of religion. Spirituality may be understood as the personal, inner, informal and emotional aspect of connecting with oneself, the environment or with the sacred (Koenig, 2004). It influences internal motives and resilience factors including underlying hope, developed through a faith system (Blaxter & Patterson, 1982; Koenig, 2004). Spirituality can be seen as an embedded concept with a belief in God as the ultimate meaning of existence and as facilitating a relationship between God and human (Hodge, 2001). Spirituality has also been approached as a separate concept from religion (or religiosity). Religious expression can be confined to particular belief systems, a formal expression of getting connected with the sacred; institutional and measurable in terms of frequency of attending rituals and offering prayers (Hodge, 2001). Pesut et al. (2008), connects spirituality with religion as a transcendental force that generates

compassion, kindness and tolerance in a person to relate to others in society. However, the confusion between spirituality and religion and a fear of offending religious sensibilities and being accused of breaching ethical codes can lead nurses to avoid the area of spirituality altogether. Imposing personal religious or secular beliefs onto patients or offering inappropriately to pray with patients are ethically unacceptable (Rogers & Wattis, 2015). A working definition which embraces spirituality and religion follows:

Spirituality can be defined as the search for meaning and purpose in life, which may or may not relate to a belief in God or some form of higher power. For those with no conception of supernatural belief, spirituality may relate to the notion of a motivating force, which involves an integration of the dimensions of mind, body and spirit. This personal belief or faith also shapes an individual's perspective on the world and is expressed in the way that he or she lives life. Therefore, spirituality is expressed through connectedness to God, a higher being; and /or by one's relationships with self, others or nature.

(Johnston & Mayers 2005, p. 386)

2.2.1.1 Influence of Western philosophy

From the Western perspective, spirituality and religion share some historic traditions of thought that have influenced existing health care. A brief overview of the historic development of the concept of spirituality in Western thought is presented here. In the early seventeenth century, prior to the enlightenment period in Western history, religion was considered as an intertwined aspect of human life, suffering and illness. Hence, spiritual care was recognised as an essential element in healing and growth. Monks and nuns as religious authorities were engaged in institutionalising health care for communities (Wilcock & Hocking, 2015). During the enlightenment phase, in the seventeenth and eighteenth centuries, scientific inquiry took over from religious dogmas and social structures (Skinner, 1978). Scientific rationalism, was seen as an opposite force to traditional religious belief (Creek, 1997). From the late nineteenth to the late twentieth centuries modernism influenced health care and rationalism largely displaced spiritual and religious approaches to care. The biomedical model based on scientific discoveries and a reductionist approach, became more dominant in health care in the last century (Christiansen & Haertal, 2014). Consequently, disease focused interventions took over from

more holistic care approaches. Post modernism, from the late 20th century to date, was associated, for some, with a radical shift in health care approaches. Whilst it was recognised that a reductionist paradigm was helpful for exploring some aspects of health care, it was now also emphasised that human experiences and aspirations could not be ignored with reference to coping, recovery and growth (Creek, 1997; Weinblatt & Avrech-Bar, 2001). As a result, today health care models emphasise person- centred care and recognise social, cultural, religious and spiritual care as essential to holistic care (Health and Social Care Act, 2012; Francis, 2013).

2.2.2 Humanistic perspectives and spirituality

Spirituality has been seen as an eternal and timeless resource to develop resilience. Murray and Zentner (1989) defined spirituality as having an ontological and existential quality.

A quality that goes beyond religious affiliation that strives for inspirations, reverence, awe, meaning and purpose, even in those who do not believe in God. The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite, and comes into focus when the person faces emotional stress, physical illness or death (Murray & Zentner, 1989, p. 259).

From humanistic perspectives spirituality is also approached as an intangible aspect of human experience and a source of motivation to connect to others, especially with reference to health. Ellis and Narayanasamy (2009) emphasise these aspects of intangibility and connection:

The inner, intangible dimension that motivates us to be connected with others and our surroundings...the guiding force behind our uniqueness (that) acts as an inner source of power and energy which makes us "tick over" as a person.

(Ellis & Narayanasamy, 2009, p. 887)

Spirituality has also been defined as including, hope, strength, meaning, forgiveness, trust, belief, faith, confidence, self-awareness, values, love, belongingness, creativity and self-expression (Narayanasamy, 2001; RCN, 2014). Congruence in values, belief, feelings and behaviour could be seen as a significant expression of spirituality (Bellingham et al., 1989; Dolan, 1993). Whilst seeing self-actualization, and transcendence as concepts related to spirituality. De Carvalho (2000) asserted

that human existence is embodied; but language, thought and intentionality takes individuals beyond what can be reduced to biological and physiological aspects. Hence, from an existential perspective, spirituality may encompass freedom, identity hope, meaning, wholeness, beliefs, and being connected (Frankl, 1969, Vachon et al., 2009). Acknowledging existential and phenomenological extensions, Cook (2013), explains spirituality from an experiential dimension as:

Spirituality is a distinctive, potentially creative, and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as a relationship with that which is intimately “inner” immanent and personal, within the self and others, and/or as relationship with that which is wholly “other”, transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth, and values (Cook, 2013, p. 04).

Such diverse definitions of the concept of spirituality in a multicultural environment have been identified as a source of confusion and complexity (Narayanasamy, 2014; Caldeira et al., 2016). However, such pluralistic approaches have also been seen as flexible and creative ways to articulate spirituality in health care, especially in nursing practice (Swinton & Pattison, 2010). Despite difficulties in defining spirituality, spiritually competent practice can be described, as Rogers and Wattis (2015) suggested:

Spiritually competent practice engages a person as a unique spiritual being, in ways which will provide them with a sense of meaning and purpose, connecting or reconnecting with a community where they experience a sense of wellbeing, addressing suffering and developing coping strategies to improve their quality of life. This includes the practitioner accepting a person’s beliefs and values whether they are religious in foundation or not and practicing with cultural competency (Rogers & Wattis, 2015, p. 53).

Hence, Spirituality is also approached as compassionate presence being attentive to patient’s physical, social, emotional and psychological needs (Puchalski, 2001; Clarke 2013).

2.3 Rationale and context of the literature review

International health care agencies and professional nursing bodies recognise spirituality as being at the core of person-centred care (Kalkim et al., 2016). The World Health Organization (2009), recognised spirituality, religion and personal beliefs as distinct components impacting on the quality of life of a person. The North American Nursing Diagnosis Association (NANDA, 2014) in developing the framework for nursing assessment in the USA, recognised spiritual care needs (Bennett & Thompson, 2015). The NANDA framework for 2015-2017 identified spiritual distress as an essential domain that needed to be addressed in order to reduce suffering and promote wellbeing (NANDA, 2014).

However, spiritual care receives little attention in nursing education (Timmins & Neill 2013; Ross et al., 2014; Lewinson, McSherry & Kevern, 2015). Discrepancies have been identified both in academic and clinical standardisation documents. On the one hand, the largest professional organisation for nurses in the UK, the Royal College of Nursing (RCN) produced online resources on spirituality in nursing care for both students and practitioners (RCN, 2011; 2015). On other hand, the UK's statutory body for the regulation of nursing skills and competency, the Nursing and Midwifery Council (NMC, 2015) designed a code for professional practice without specific mention of spirituality. Similar issues have been identified around the world, including in the USA, (Chan & Chung, 2004; Yilmaz & Gurler, 2014; Lewinson et al., 2015). Over the last two decades there have been a number of calls to integrate spiritual care into nursing education across the curriculum. However, there is no consensus about how this can be done (Narayanasamy, 1993; Benner et al., 2010; McSherry & Jamieson, 2011; Ross et al., 2014; Yuan & Porr, 2014; Lewinson et al. 2015; Caldeira, et al. 2016, Kalkim et al., 2016).

To overcome the gap between aspirations and practice, it is necessary to understand how spirituality is currently approached and to what extent student nurses feel competent in assessing and delivering spiritual care in practice. Hence, a literature review was planned to explore current knowledge and practice and identify the gaps in addressing spirituality in nursing education.

2.4 Aim

This literature review aimed to identify what was currently known about developing nursing competencies in assessing and addressing patients' spiritual care needs in undergraduate education.

2.5 Methodology

A literature review covering the period 1993-2017 was performed, using a systematic approach to ensure a high level of validity and reliability (Aveyard, 2014). The period of the last two decades (1993-2013 initially) was chosen deliberately so that a wide understanding of the subject area could be generated and to enable any evidence for trends towards improved education in this area to be noted. In addition, the underlying factors that influence shaping nursing education and quality care standards could be revealed. The literature review was the foundation upon which this study was built and the final product represents a synthesis of findings from this study against a background of research by other investigators who have also contributed to the exploration of the factors influencing the integration of spirituality in nursing education (Robson & McCartan, 2016).

The period initially specified was from 1993-2013. The literature search was kept up to date and repeated towards the end of the study (April 2017) to ensure full account was taken of other work in this field. The initial review enabled a wider understanding of the issues when I came to finalise my research question (Ali, Wattis & Snowden, 2015). This understanding enabled me to draft my research questions to bring more focus, rigour and exclusivity to this research project. The systematic review process approach enabled me to develop clarity in designing a structural framework for navigation, investigation and interpretation of the identified study areas (Booth, Papaioannou, & Sutton, 2012). The review aimed to identify and evaluate all relevant literature that met predefined inclusion and exclusion criteria. The documentation of the inquiry process, enabled a consistent and replicable analysis and synthesis of relevant knowledge (Jesson, Matheson, & Lacey, 2011; Booth et al., 2012; Aveyard, 2014).

The search strategy included setting inclusion and exclusion criteria, deciding key terms, language(s) and period searched, and type of sources to assure the quality and rigour of findings (Booth et al., 2012).

2.5.1 Inclusion Criteria:

English language publications in indexed and peer reviewed journals (1993-2017) which addressed the key question of how undergraduate nurses were prepared to assess spiritual care needs were

included. Online articles, reviews, reports, quantitative and qualitative studies were included, provided they were peer reviewed.

2.5.2 Exclusion Criteria:

All “grey” materials including letters to the editor, short editorials, online books, chapters, comments and unpublished work were excluded using methodological filters, as those sources were not methodologically robust (Booth et al., 2012; Aveyard, 2014). Studies based on unpublished quantitative tools or without robust qualitative or quantitative evaluation strategies were excluded to maintain the credibility of the research findings (Aveyard, 2014).

2.5.3 Online Searches

Online searches were conducted using CINHAL, PubMed Nursing and Midwifery Council (NMC), Royal College of Nursing (RCN), The University of Huddersfield Library Catalogue, The University of Huddersfield Electronic Library (Summon), The University of Huddersfield Repository and Google Scholar.

2.5.4 Key words

The following key words were used: Spirituality OR/AND spiritual care in the pre- registration nursing curriculum, spiritual care AND nursing students, spiritual care AND nursing educators, spirituality OR/AND spiritual care in nursing education.

2.5.5 The process of data Extraction

The title, abstract and (where relevant) the full text of each article was scanned to establish whether it met the inclusion criteria (Booth et al., 2012). Articles meeting the inclusion criteria, were read carefully, analysed and any relevant references that met the inclusion criteria and were not already identified were followed up and included in the analysis (Fink, 1998; Booth et al., 2012; Aveyard, 2014).

CASP (2013, 2017) advised on setting criteria for establishing the quality of each article for data extraction. This included, commenting on the research design, sample size, methodology used, validity and reliability measures and a critique of any potential bias with reference to conclusions. The literature review also highlighted strengths and weaknesses of each study to enable discussion of the

implications and further scope for research. A review grid drawing upon the meta-summary approach illustrated by Aveyard (2014) was developed to compile the details of all selected articles (Appendix 1). The aim of the grid development was to project the compiled data in a logical and chronological order to facilitate comprehension. Through the grid presentation, underlying themes, the scope and implications of several scholarly discussions and research studies were categorised for further evaluation using the Critical Appraisal Skills Programme guidelines for literature review (CASP, 2013, 2017).

A hierarchy of evidence was established for each theme ensuring critical appraisal of each study identified and seeking to reduce personal bias to a minimum (Booth et al., 2012; Jesson et al., 2011; Aveyard, 2014). Summary notes were also developed both through hand notes in diary entries and online endnote memos, to keep track of and record any excluded documents, highlighting the reasons for exclusion for future reference. Summary notes and diary entries are considered useful and very effective to develop critical insight about personal views and avoiding biases while performing literature searches (Langdrige, 2007; King & Brooks, 2017).

For all selected articles, the data extraction tool was primarily endnote software along with manual record keeping, of the nature of each study, methodology used and publication details (Fink, 1998; Jesson et al., 2011; Booth et al., 2012; CASP, 2013, 2017).

2.6 Findings

One hundred papers were originally identified and after excluding Sixty-nine, that did not meet the inclusion criteria, thirty-one papers were considered for review. No additional papers that met the inclusion criteria were identified from the references in these papers. Each study was evaluated for its research design, sample size and assessment criteria to analyse the validity and reliability of the research findings. After identifying the strengths and weaknesses of each study, a review grid using the meta-summary approach illustrated by Aveyard (2014) was developed. Details of selected research studies were compiled chronologically. Findings were categorised thematically to develop a logical review structure (Appendix 1), using CASP (2013, 2017) guidelines.

The following themes were identified:

1. Quantitative Assessment Tools on spiritual care competency (10 papers)
2. Approaches used to integrate spirituality in nursing education (10 papers).
3. Inclusion of Spirituality in Nursing Texts or Curriculum (5 papers)
4. Views from Nursing Educators (4 papers)
5. Perspectives from Nursing Students (2 papers)

Findings are presented in more detail by theme below:

2.6.1 Quantitative Assessment Tools

Various tools have been developed to inquire about the nature of students' learning experiences and attitudes towards developing spiritual care awareness (Lewinson et al., 2015). Properly developed standardised quantitative measures that are valid, reliable and sensitive to change, enable meaningful comparisons between groups and within groups over time. The Spirituality and Spiritual Care Rating Scale (SSCRS, Mc Sherry et al., 2002) is a seventeen-item Likert scale with demonstrated reliability and validity and it has been used in a number of studies relating to the integration of spirituality in the nursing curriculum. Wallace, Campbell, Grossman, Shea, Lange and Quell (2008), and Tiew, Creedy and Chan (2013), have used this scale and found it effective in understanding students' needs and reflections about spirituality in nursing education. The Spiritual Care Competence Scale (SCCS, van Leeuwen et al., 2007) also has demonstrated reliability and validity and is based on Spiritual Care Competencies identified by van Leeuwen and Cusveller (2004). This scale was also used by Costello et al., (2012) and, alongside the SSCRS, by Ross et al. (2014). The Spiritual Care Giving Scale, developed and validated by Tiew and Creedy (2012) is discussed below. The World Health Organisation (WHO) QOL Spirituality, Religiousness and Personal Beliefs (SRPB) Group (2006) produced a Field-Test Instrument which measures quality of life alongside questions on spirituality and religion. A cross-sectional study using the Australian version is briefly reported below. Despite the currency of these scales others have continued to devise their own quantitative assessment tools for use in this area (e.g. Nardi, Faan & Rooda, 2011). Even the best of these scales could be questioned because they only provide quantitative information and only measure what they measure whereas

qualitative approaches may be better for developing new insights (Robson & McCartan, 2016). The main scales identified and studies using them will be briefly discussed below.

2.6.1.1 *The Spirituality and Spiritual Care Rating Scale (SSCRS)*

McSherry, Gretton, Draper, and Watson (2008) explored the ethical basis for teaching spirituality and spiritual care to nursing students, through an exploratory longitudinal study. One hundred and seventy-six nursing students progressing from year 1 to year 3 in the BScN programme, participated in the study which aimed to explore changes in students' perspectives, as they progressed through their studies. Questionnaires using the validated SSCRS (McSherry et al., 2002) were used for data collection. Findings suggested that students associated spirituality with existential ideas and were uncertain about making judgements on or being instructed in spiritual matters because of fears that it would be unethical to comment on individual values and belief systems. Arguably, qualitative explorations focusing more upon underlying fear and associated ethical dilemmas could inform more about student's needs and learning requirements with reference to nursing education.

Wallace et al. (2008) used the SSCRS (McSherry, 2002) to evaluate learning outcomes among junior and senior undergraduate nursing students. Significant differences ($p < .05$) were reported between pre- and post- test scores. Twelve nursing courses were reviewed and discussed with educators. The study acknowledged that spirituality is implicitly embedded in the nursing curriculum however, course-specific guidance enhanced the nurses' understanding as evidenced by the improved scores on the SSCRS. The study emphasised that spirituality should be threaded across the nursing curriculum in each course. Moreover, it could be useful to develop opportunities for students to reflect more on their own spirituality while preparing them to address patient's spiritual care needs. An integrated multidisciplinary curriculum covering philosophy, ethics, religion and transcultural care could be effective in expanding students' knowledge and understanding about spirituality. In addition, professional support from administration and academic faculty is required to integrate spirituality in nursing education. This was a well-structured study that briefly discussed approaches to innovation in teaching spirituality in undergraduate nursing curriculum and suggested a way forward.

Kalkim et al. (2016) explored student nurses' perspectives on spirituality and spiritual care at a nursing school in Turkey. The data was collected using a self-reported questionnaire which included: sociodemographic details, knowledge and practices of spirituality and spiritual care form, and the

Spirituality and Spiritual Care Rating Scale (SSCRS). The Turkish version of SSCRS was used and reported validity and reliability of the SSCRS. Student's perceptions (n=400) from one school of nursing, were explored in a descriptive survey using the SSCRS. Inadequate integration of spirituality in nursing education was reported by nursing students. Knowledge and practice gaps due to time and work load constraints, along with lack of clarity from nursing educators were identified as major challenges by the students. Students related spiritual care to personal experiences and belief systems. However, because of the limited sample size, the study findings cannot be generalised. Several other studies conducted on Asian nursing students identified similar concerns of limited competency and lack of preparedness in relating to spiritual care issues because of the knowledge and practice gap in nursing education (Tiew & Drury, 2012; Tiew & Creedy, 2012; Cooper, Chang, Sheehan & Johnson, 2013; Lopez et al., 2014). These studies highlighted the need to acknowledge spirituality, multicultural and multi-faith issues, internationally.

2.6.1.2 *Spiritual Care Competence Scale*

Van Leeuwen et al. (2008) studied the effect of a course for nursing students on developing competence in spiritual care. The Spiritual Care Competence Scale (van Leeuwen et al., 2007) was used to measure change. Ninety-seven undergraduate nursing students from two Christian nursing schools in the Netherlands were divided into two groups. As the intervention group, half of the students were assigned a clinical placement for four months. The remaining half of the students were part of a control group. Control group students participated in a six-week education programme developed by the researcher (van Leeuwen and Cusveller, 2004). A pre-and post-test evaluation was done on both groups, using the Spiritual Care Competence Scale (SCCS) (van Leeuwen et al., 2007). The results identified that students in control group; who attended the education course, had raised proficiency in planning and delivery of spiritual care. Even the intervention group showed more competency after four months of clinical experience. Statistically not much difference was identified between both groups. However, the validity of students' self- perception of spiritual care competency is debatable. Costello, Atinaja-Galler, and Hedberg (2012) investigated if simulation could be used as a teaching and learning method for discussing spiritual care concepts with students. A pilot study was carried out with a convenience sample of fifty-two students. A quasi-experimental, pre-test–post-test design was used. The validated, Spiritual Care Competence Scale (SCCS), was used to measure change (van Leeuwen, Tiesinga, Middel, Post & Jochemsen, 2009). This tool measured six spiritual-

care-related nursing competencies. The study was conducted in the simulation laboratory of a private liberal arts college in the Northeast, USA. The simulation activity was found to be very effective as a teaching and learning strategy, as it allowed students to practice therapeutic communication and use the nursing assessment process on given narrative scenarios focused on spiritual distress. A statistically very highly significant change was found in the SCCS results after the module. The competencies showing improvement at a high level of significance included acknowledging spiritual needs of their patients, making referrals, assessment of spiritual needs, and personal support and patient counselling. Students also reported that discussing spirituality during the simulation session helped them to become more reflective in relating spiritual care to clinical scenarios. Although the generalizability of the research findings could be questioned on a number of grounds, the study could be considered as a milestone in addressing phenomenological aspects in nursing education, where subjective experiences of grief, suffering and spiritual distress were acknowledged using simulation as the teaching intervention.

2.6.1.3 Studies using both the SSCRS and the SCCS

Only one study was found that used both the SSCRS and the SCCS. To explore the development of student nurse competencies in delivering spiritual care Ross, et al. (2014) studied six universities in four European countries (Wales, Malta, Netherlands, and Norway). They used a variety of validated scales including the SSCRS (McSherry et al., 2002) and The Spiritual Care Competency Scale (SCCS, van Leeuwen et al., 2009). Students were generally found competent to approach spirituality from a humanistic perspective based on personal understanding. Some students, based on their personal values, had prior understanding about religious sensitivity. However, those students also reported that they felt less competent in approaching spiritual care needs, particularly with reference to nursing assessment and planning care. A potential bias arose from the student group being relatively homogenous with respect to (European) cultural background. The study did not explore the role of nursing educators and curriculum components in developing spiritual competencies.

2.6.1.4 Spiritual Care-Giving Scale (SCGS)

Tiew and Creedy (2012), developed the Spiritual Care-Giving Scale (SCGS) to measure student nurses' perceptions of spirituality and spiritual care. A pilot study was conducted in Asia. The 35-item

SCGS was administered to a convenience sample of seven hundred and forty-five final-year nursing students. Internal consistency and the test–retest reliability was demonstrated.

Tiew et al. (2013), used the SCGS in a descriptive cross-sectional design to examine the views and attitudes of sixty-six hospice nurses Singapore to gain a perspective from Asian students. The study identified that knowledge about spiritual awareness was independent of students' age. However, the study lacked clarity in defining how spiritual care competency could be developed in multicultural and diverse ethnic environments. The study emphasised that nursing leaders, educators and regulators, should work together in developing an integrated nursing curriculum. They also emphasised the need for adequate professional training for teaching faculty in this area. Further studies are required to establish the sensitivity to change of this scale and whether there are any advantages in using this tool specifically within the multicultural and diverse ethnic contexts.

2.6.1.5 World Health Organization Quality of Life-Spirituality, Religiosity and Personal Belief, (WHOQOL-SRPB)

A cross-sectional survey (Lopez et al., 2014), was developed to explore Australian nursing students' perceptions of spirituality, religiosity, and personal belief. A carefully developed and well validated 32-item WHO-QOL-SRPB questionnaire (World Health Organization Quality of Life-Spirituality, Religiosity and Personal Belief, WHOQOL SRPB Group, 2006) was used. The study was conducted at a nursing university using a convenience sample of undergraduate student nurses (n=863). Results were found to be independent of the gender of the students. Students with religious beliefs had scores that were significantly higher than those with very little or no personal belief and varied with years in training based on their professional experiences. The study recommended that nursing students should understand their own spirituality before approaching patients' spiritual issues and that students were likely to have a range of perspectives on spirituality based on their academic levels, and their personal and professional exposure. However, the study was conducted at one university in Australia; hence the findings cannot be generalised. Twenty other studies using this questionnaire that is produced in different language and cultural versions have been located referring to studies of various patient groups and one looking at generic health care workers but not looking at nurse education.

2.6.1.6 Spirituality Scale

Nardi, et al. (2011), performed an exploratory mixed-method study to develop a practice theory of spirituality-based nursing designed to teach how to integrate metaphysical and spiritual aspects into nursing care. In this case, a spirituality scale was devised specifically for the study. A comprehensive review of current textbooks, published papers, and research on holistic nursing and spirituality found 45 statements on personal spirituality which were converted to a Likert scale questionnaire to inquire about knowledge and application of a metaphysical dimension of human health. The overall consistency and stability of the items in the scale was checked. A purposive sample of eighty-six final year nursing students was taken from two schools. There was no significant difference in spirituality scores between the groups, with an overall mean spirituality score of 128.76 from a maximum possible score of 188 (range 76 to 161). This study was just a baseline measurement, comparing two schools with no follow up. As a result, a practice theory of spirituality-based nursing was developed, which could be used as a source for innovative ideas in relating metaphysical aspects of health, wellbeing and spiritual care. However, this study did not address whether or how the existing curriculum met these needs.

2.6.2 Approaches used to integrate spirituality in nursing education

A number of teaching and learning approaches were found that aimed to integrate spirituality in undergraduate nursing education. These will be discussed under the headings of application of nursing theories and models and teaching and learning methodologies.

2.6.2.1 Application of nursing theories and models

The ASSET (Actioning Spirituality and Spiritual Care Education and Training in nursing) Model (Narayanasamy, 1999a) emphasised the importance of self-awareness in nurses and patients for sustaining therapeutic relationships. This model embraces the entire nursing process from assessment to evaluation and elaborates upon competencies required to build and sustain the nurse-patient relationship on spiritual grounds. It largely explains the nurse-client relationship from a psychological perspective rather than defining it on ontological grounds. However, existential and biological perspectives were discussed in the paper, which can be viewed as a significant attempt to bring a wider understanding to articulating the concept of spirituality in nursing education. Baldacchino (2008, 2010), used the ASSET model in Malta for both undergraduate and post-graduate nursing

students but the studies were limited by an exclusively Judaeo-Christian orientation and lacked adequate evaluation. Several teaching and learning methods including case study presentation and reflective exercises were part of this study programme. The participants were all from one religious affinity that is Christianity potentially limiting more general applicability. The study was purely a descriptive account of applying a model without any systematic evaluation on qualitative or quantitative grounds.

Barss (2012a), described the development of the “TRUST” (Traditions, Reconciliation, Understandings, Searching, and Teachers) model for understanding spiritual care needs of patients. This model is anchored in experiential learning and could be useful in teaching students the importance of developing self-awareness and intentionality. However, it lacked detail on how to develop the required competencies of self-evaluation or continuous self-transformation in both learners and nursing educators. Only one study (Barss, 2012b) discussing the impact of the TRUST model has been found. However, owing to the small sample size and lack of multicultural perspectives, its wider applicability is questionable.

Hoover (2002), applied Watson’s transpersonal caring-healing model (Watson, 1999), in developing caring competences in nursing students through a 15-week module. A focus group before and after the module on caring, was used for evaluation. Findings included transformation on both personal and professional grounds. Major themes identified included the following:

- Increase in self-awareness
- Finding meaning and connecting with self and others
- Value clarification
- Increased knowledge regarding the concept of holistic care.

The study generated a broad reflective account of students learning experiences and related the caring ethos to spiritual care. However, this study did not recommend any core units to be introduced into the nursing curriculum to integrate spiritual care as a legitimate part of holistic care.

Burkhart and Schmidt (2012), developed a Spiritual Care Educational and Reflective Program (SCERP), based on Burkhart and Hogan’s Spiritual Care in Nursing Practice theory (2008). The

theory recognises spiritual care-giving as an interactive discourse in nursing practice. Hence the programme does not consist of assessment questions and prescribed interventions, but focuses on meaning-based monitoring and compassionate care to promote hope and meaningfulness in life. SCERP was evaluated for its efficacy through a pre-post-test, randomised controlled trial on nursing students (n=59). SCERP was both face-to-face and online for students, enabling intellectual debates and self-awareness. Reflective practices learned through SCERP, were found to be effective in developing students' competence in understanding and approaching the spiritual care needs of patients and families. Possible weaknesses were the small numbers involved and that it was a short-encapsulated programme, over a six-week clinical experience and there was no follow up to assess whether changes persisted. Data were gathered using validated tools. The Spiritual Care Inventory (SCI) was used to measure the provision of spiritual care (Burkhart, Schmidt, & Hogan, 2011). The well validated Spiritual Well Being Scale (SWBS), was used to measure the nurses' spiritual well-being (Paloutzian & Ellison, 1991). This last scale combines two 10-item scales, one assessing "religious well-being" (RWB - relationship to God) and the other existential well-being (EWB). The SWBS showed no significant changes between the beginning and end of the course although there was a trend towards some effect on the EWB sub scale ($p = 0.08$). However, the intervention group manifested higher post-test scores on the SCI. The study found student nurses' eager to learn skills to provide spiritual care. It concluded that an integrated theory with a process-oriented approach might be useful in teaching spiritual care. The study was conducted in a faith-based nursing school, hence there could be a potential bias from the faith perspective. The RWB subscale of the SWBS is known to have a ceiling effect in religious people and this may explain the lack of positive change on this scale and subscale. Nevertheless, it provides a strong framework for devising and assessing further courses to develop clinical competency in spiritual care.

2.6.1.2 Teaching and Learning Methodologies

Alongside nursing theories and models, some innovative methods were found that aimed to incorporate awareness of spirituality in nursing education. These included using the medium of art to prepare students for phenomenological inquiry, understanding students' own perceptions of spirituality and spiritual care, the role of nursing educators in developing required spiritual care competencies and developing certain encapsulated programmes to facilitate the understanding of

spiritual care concepts based on some pedagogical approaches. A brief account of these innovative approaches is given below.

Self-reflection has been emphasised in the nursing literature as a means to teach and experience spiritual ideas. Bush (1999) introduced journaling as an effective self-reflection tool to teach the concept of spirituality. Journaling could be considered a useful strategy to enhance self-awareness. An informal Likert scale questionnaire was used to assess students' learning through journal writing, at the beginning and end of the study. The findings reported that students showed keen interest in learning more about spirituality but expressed confusion about the term spirituality and its scope of practice in nursing. A need for developing a formal teaching framework for nursing educators was recognised by the study, so that a safe and open discussion could be facilitated in classrooms, acknowledging students' diverse background and personal experiences.

Mooney and Timmins (2007), attempted to teach and incorporate spiritual concepts in an innovative way. Along with class room teaching activity, nursing students were taken out on a museum visit to engage in a reflective activity to comprehend spiritual aspects through the medium of creative Arts. Although, the study initially involved 160 students in the teaching and museum visit, only 21 participated in the focus group evaluation. The article gives little description of the nature of spiritual themes covered in the teaching sessions prior to the museum visit. However, the underlying philosophical structures anchoring the teaching marks this study as a significant step in approaching spirituality from a phenomenological perspective.

Virtual teaching methods were also proposed to teach compassionate care, empathetic communication and how to address spiritual care needs (Taylor, Mamier, Bhjri, Anton, & Peterson, 2009). A self-study programme based on a workbook with a supplemental DVD and self-report study instruments were used to understand the attitude formation of course participants towards spiritual care giving. Qualitative tools used in this study were: The Response Empathy Scale (Elliott et al., 1982), the Spiritual Care Perspective Scale-Revised (Taylor et al., 1999), a ten item Likert scale and the Daily Spiritual Experience Scale (Underwood & Teresi 2002), a 16-item Likert scale. There were 201 participants including nursing students and registered nurses. A pre-test and post-test experimental design was used. The *Communicating for Spiritual Care Test* (CSCT) created by the

principal researcher was used to evaluate the communication practice on a 24 items true/false test. The findings suggested that the self-study programme was useful for both student and graduate nurses in developing understanding about their own spirituality and understanding the spiritual care needs of their patients. However, the validity of the CSCT tool was not illustrated in the study, hence the reliability of the findings on this scale are questionable.

2.6.3 Inclusion of Spirituality in Nursing texts or curriculum

Five research studies were found exploring the degree of inclusion of spirituality and spiritual care concepts in nursing textbooks and the curriculum.

Callister et al. (2004), conducted a survey of 132 baccalaureate nursing students in the United States of America, and reported that although the concept of spirituality has been mentioned in nursing courses, it was judged to be inadequately articulated across all nursing courses. The authors presented a curriculum model to integrate spirituality and spiritual care aspects across several nursing courses including: maternal and child nursing, critical care, oncology and community health nursing courses. The model was found to be successful, evidenced by qualitative analysis of the students' reflections gathered through journal writing. However, the findings were based on responses from one university in America, limiting the scope of generalisability.

Kenny & Ashley (2005) recommended the need for a specialised curriculum to train student nurses in understanding and addressing spiritual care needs of children and their families. A questionnaire was developed and validated through a pilot study. The study identified knowledge-based challenges in understanding children's spiritual care needs. The study could be a valuable contribution for encouraging student nurses to explore creative ways to engage with children and their families.

Timmins et al., (2014), studied core nursing text books (n= 580), after developing a tool, called the Spirituality Textbook Analysis Tool (STAT), validated by Polit and Tatano-Beck (2012). In general, nursing text books were found to be consistent in offering some guidance and direction around spiritual care. However, few provided relevant detail on spirituality by discussing various definitions, exploring the relationship of spirituality to religion or discussing the role of the nurse in assessing spiritual distress or offering tools for assessing spiritual care needs in practice. The study recommended that nursing texts should be strengthened by providing a consistent focus on spirituality

and including spiritual care themes. This study demonstrated the relatively poor coverage of spiritual care in nursing texts. It did not provide a thematic or conceptual analysis of how the term spirituality was used in nursing texts.

Yilmaz and Gurler (2014), explored the efficacy of a revised and integrated undergraduate curriculum compared with a traditional nursing curriculum in Turkey. A quasi-experimental post-intervention two-group design was conducted from 2009-2011 covering different academic years. A total of 130 students participated. The SSCRS (Mc Sherry et al., 2002) was used to evaluate the impact of an integrated, spirituality focused curriculum. The intervention group consisting of students exposed to an integrated curriculum, scored significantly better on the SSCRS than a control group, using a traditional nursing curriculum. The study emphasised the need to revise the existing nursing curriculum to integrate spiritual care. This study could be considered as a pioneering step in reconstructing a national nursing curriculum, recognising spiritual care as an essential part of nursing education.

Murphy et al., (2015) explored how spiritual care content is introduced in children's nursing text books, used in undergraduate teaching. Five hundred and nineteen books were selected from the Nursing and Midwifery Core recommended list (UK) using a validated survey tool, the Spirituality Textbook Analysis Tool (STAT), Timmins et al., 2014), validated by Polit and Tatano-Beck (2012) for data collection. Thirteen books included content on children's spirituality, however, only two aspects of spiritual care were identified: religious faiths and the dying child. The study recognised lack of content and limited perspective on spirituality in nursing text books children's nursing. This research complemented the findings of Kenny and Ashleys' (2005) earlier study on children's nursing and recognised that children's' development needs and stages of faith formation are not necessarily equivalent to adults' spiritual care needs. Hence, adequate knowledge and competency should be provided in undergraduate nursing curriculum and teaching practices by revising the content in nursing text books.

2.6.4 Views from Nursing Educators

There is a shortage of research recognising the experiences and concerns of nursing educators in relation to spiritual care concepts in nursing education (McSherry & Draper, 1997; Caldeira et al., 2016). Only four studies were found that addressed this area.

McSherry and Draper (1997) identified those influencing factors that often became a barrier for educators in relating spiritual care aspect in nursing education. These barriers were a) the time needed to develop skills for assessing spiritual care needs of patients, b) the need for competent mentoring for students performing spiritual care assessment, c) managerial issues related to financial implications, d) the work load on nursing educationists in revising the existing curriculum and e) a lack of acknowledgement of the role of cultural diversity in this area. Although the article identified barriers with particular reference to the UK in 1997, similar issues have been identified in other parts of the world (Yuan & Porr, 2014; Lewinson et al., 2015).

Cone and Giske (2012), used grounded theory to inquire how to teach spiritual care by conducting a study of how nursing educators said they prepared students to understand and assess for spiritual care need. The study was conducted through five focus group studies, from nineteen nursing educators at three Norwegian university colleges. The study recognised the need of an explicit and continuous integration of spirituality in both teaching and practice. The study suggested that spirituality could be integrated in the nursing curriculum by encouraging students to do essential reading on the subject, encouraging reflection through case studies in group discussions, role plays and formal examination. The grounded theory identified the students' need to learn spiritual care through *maturation* enabled by role modelling in clinical care. However, challenges in incorporating spiritual issues in the curriculum, were not explored.

Barss (2012b), explored clinical experiences of nurse educators using the TRUST model (Barss, 2012a). In-depth interviews were undertaken with four nursing educators using an interpretative phenomenological approach. Participants recognised that the TRUST model was very helpful for themselves and for students in building rapport with patients and engaging in the spiritual inquiry process. However, they also identified some barriers which included; the lack of recognition of the relationship between general health and spiritual care, insufficient time for students to provide spiritual care due to prioritising physical complaints, and role ambiguity of both students and educators when offering support in cases of spiritual distress. Since, it used a phenomenological research, it was a small group study. The findings cannot be generalised because of this and because the study lacked multicultural perspectives. Nevertheless, it provided helpful insights into the issues faced in addressing spirituality in education.

Caldeira et al. (2016) performed a cross-sectional descriptive study using an electronic questionnaire. The study was conducted in 2014-2015 across various nursing schools in Portugal and Brazil. One hundred and twenty-nine email responses from nursing educators revealed that though they recognised spirituality as an important component in undergraduate nursing education, it was not recognised as an established teaching practice due to personal interest and work load pressures. A wide scope for integrating spirituality in various nursing courses and several creative teaching and learning approach were also identified by the educators. The study identified the need for a standardised curriculum with explicit representation of spirituality across nursing courses. They concluded this should cover both theoretical and clinical knowledge base with time specification in the syllabus, along with suggested strategies. The study is a timely contribution to understand the issues and challenges faced by nursing educators. However, due to the small sample size of educators based on their personal interest, the findings cannot be generalised for all educators across the country. Also, a detailed qualitative study could be more useful to explore potential barriers in relating spirituality in nursing curriculum.

2.6.5 Perspectives from nursing students-Qualitative studies

Only two qualitative studies exploring students' experiences and concerns about spiritual care were identified.

Giske and Cone (2012) explored undergraduate nursing students' perspectives on spiritual care and how they learned to assess and provide spiritual care in a qualitative study. Grounded theory was used to explore the competencies perceived by nursing students to prepare themselves to assess and respond to patients' spiritual needs. They highlighted the need to integrate existential and spiritual components more explicitly in nursing education. Evaluative discussions on clinical interventions and role modelling from some nursing educators were appreciated by students. Interpersonal relationships between nursing educators and students and between students and patients were thought to provide an enabling spiritual environment. There was no discussion of other course components, evaluation criteria or curriculum design with reference to integrating spirituality in nursing

Strand et al., (2016) using a qualitative evaluation design studied the impact of a partnership-initiated intervention to explore student's learning and competency development in spiritual care giving. Some

Norwegian university college students were provided mentorship to practice spiritual care in a church-affiliated hospital ward. Three focus group studies on students found that the mentorship initiative enhanced their understanding and competency in approaching patients in clinical areas. Students reported themselves more confident and active in engaging patients to address their spiritual care needs. Clinical mentorship and role modelling provided by the participant nurses, significantly impacted students' views about spirituality and how it was related to health practice. This study could be a useful model to bridge the knowledge and practice gap in nursing education and clinical practice. However, more studies are required to establish the impact of this model in multicultural and non-faith based hospital settings.

2.7 Limitations

Based on the inclusion criteria, all relevant search results were identified to avoid any personal bias. However, search results were further filtered and analysed. There were several hits, where the title and abstract fulfilled the inclusion criteria, but no text was found online due to copy right access issues. Only those articles were selected for further analysis where a complete online, full text could be accessed in English language.

2.8 Discussion on Findings:

The literature review revealed that most of the studies have been conducted on how to teach spirituality to nursing students. Several quantitative scales have been developed and evaluated to assess nurses' attitudes to spiritual care and spiritual care competencies. Of these the SSCRS and the SCCS seem to be the most widely used but other scales have been adapted from different contexts (e.g. WHOQOL-SRPB) or developed for specific applications. Qualitative evaluations (e.g. using focus groups) have also been carried out. Several teaching and learning methodologies including teaching models, quantitative tools, small courses, and learning strategies have been developed to integrate spirituality in nursing education. These were generally reported to be useful for the participants in developing their understanding of and confidence about spiritually competent care (Nardi et al., 2011; Cockell & McSherry, 2012; Cone & Giske, 2012; Bennett & Thompson, 2015). However, there are several knowledge and practice gaps and influencing factors which pose a challenge to integrating spirituality in nursing education. A detailed discussion of these knowledge and practice gaps is presented below.

2.8.1 Knowledge and practice gap 1: Lack of ontological integration

The literature review showed that teaching strategies based on humanistic philosophy and acknowledging the need for self-awareness, compassionate caring, cultural and religious sensitivity were common approaches to teaching about spirituality (Narayanasamy, 1999a; Barss, 2012a). However, the ontological concept of being and becoming as a way of developing spiritual understanding and competency was not well explored. Being can be understood as the essence of the person, which expresses itself through various opportunities (Kang, 2003). With reference to nursing, actions guided by personal intentionality and reflection define the very being of nursing care (Flaming, 2004). Hence, it is vital to establish how intentionality and care- giving attitudes can be developed through nursing education. This calls for integrating ontological aspects in nursing education.

From an ontological perspective, spiritual nursing care can be seen as, '*... an intuitive, interpersonal, altruistic and integrative expression that rests on the nurse's awareness of the transcendent dimension yet reflects the patient's reality*' (Sawatzky et al., 2005, p. 30). Martinsen (2006) has characterised nursing as self-commitment and invocation rather than being just a task-based profession. Martinsen further differentiates the care approaches and identifies the objective and physiological dimension of care as the recorded eye of a nurse. However, the recorded eye can only see the physiological and recordable aspects of patient's need. Hence, she emphasises developing a perceiving eye, through which a nurse can connect with patients to understand patient's care needs (Martinsen, 2006). Such professional commitment requires nurses' emotional openness and availability to their patients. Hence, for such emotional engagement, nurses should be prepared to understand their own ideas of self and being and to extend empathy and vulnerability to their patients' existential and ontological needs (Thorup et al., 2012).

The role of nursing educators and clinical mentors becomes very critical here to orient students with professional values, skills and competencies required to embrace the healthcare policies and caring practices. Through professional socialisation, student nurses internalise values, norms and develop an identity that is accepted by their educators, and recognised by the wider health care team members (Taylor et al., 2001). Student's professional identity is significantly influenced by the values

and attitudes practiced by their educators and mentors (Johnson & Cowin, 2012). Hence, by providing mentorship and encouraging students' self-reflection, nursing educators can promote congruent nursing presence. Brown (2010) suggested that by embracing one's own imperfect self, a person can develop self-acceptance and congruency. By acknowledging personal fears and knowledge deficiencies, both nursing educators and students can be facilitated to develop a true and authentic self that could then be sensitive and available to understand others' spiritual care needs (Rogers, 2016).

The literature review identified that enabling student nurses to develop themselves vocationally required professional effort particularly with reference to developing clarity in the nursing curriculum and providing opportunities for transformative learning through reflection and mentorship.

2.8.2 Knowledge and practice gap 2: Lack in phenomenological understanding

Many nurses experience lack of preparedness in meeting the spiritual needs of their patients due to; *'...mismatch between the expectations of education and the reality of practice'* (McSherry 2000a, p. 40). One of the underlying causes of such mismatch, is a focus on 'objective' rather than the 'subjective' truth. This has influenced learning and care approaches used to train nurses in undergraduate nursing education. Benner (1994, p.12) explained that *"... it is necessary to view patients as subjects, not objects; as either acting rationally, or irrationally due to 'causes'"*.

Several tools have been developed to quantify understanding of spiritual aspects of care. However, spirituality can never be entirely comprehended through psychometric analysis using positivistic methods of inquiry (Swinton, 2012). Positivistic inquiry methods are objective and results are based on empirical evidence that can be tested and measured. Qualitative methods explore subjective interpretations and the process of meaning-making (Robson & McCartan, 2016). Hence, qualitative methods are appropriate for inquiring into the nature of meaning-making discourse, relevant to understanding spirituality (Swinton, 2012; King & Brooks, 2017). Swinton (2012) asserts that there are different kinds of knowledge which he characterises as nomothetic and idiographic. Nomothetic knowledge is the kind that can be quantified. In scientific terms, it can be tested and falsified. Providing that appropriate methodology is used, findings from this kind of knowledge can be generalised. Idiographic knowledge is subjective and experiential. It is this latter form of idiographic

knowledge that is required to develop insight and understanding about spiritual care. At the personal level, this kind of knowledge is subjective and cannot be falsified, tested or generalised using quantitative methods. At a group level, it is possible to devise quantitative tools such as questionnaires to measure changes in understanding and delivery of spiritual care. A number of quantitative tools exploring students' needs and understanding about spirituality have been developed and used to evaluate and strengthen teaching and learning strategies in this area (McSherry et al., 2002; Tiew & Drury, 2012; Tiew & Creedy, 2012; Lopez et al., 2014).

Idiographic knowledge cannot be empirically gained using quantitative tools or measurements (Swinton, 2012; Wattis et al., 2017). Idiographic knowledge and insight can be studied using qualitative methods where the meaning-making process can be recognised and interpreted. Swinton (2012), also asserts that nomothetic knowledge which can be measured through scientific experiments may not be effective and appropriate at the personal level in gaining insights about spirituality. Quantitative methods offer a limited understanding of students' learning experiences and the factors behind the identified conceptual difficulties (Robson & McCartan, 2016). Exploring how students interpreted and expressed their experiences on quantitative scales leaves a gap in understanding. The understanding of meaningfulness, value-based knowledge and behavioural transformation can be developed using qualitative approaches (Wattis et al., 2017). Perhaps, a more integrated learning and assessment approach is required to design a competent nursing curriculum. Carl Rogers' work on developing client or person-centred care through empathy, congruence and unconditional positive regard (Rogers, 1959) is relevant here. By applying Rogerian person-centred approaches in education, students can be enabled to develop congruence, acceptance and empathy through learning facilitation and mentorship (Carlin et al., 2012). This involves developing phenomenological, subjective and inter-subjective understanding in student nurses.

2.8.3 Knowledge and practice gap 3: Lack of support and environmental constraints

Studies on exploring students' views revealed that the existing nursing curriculum does not appear adequately to prepare nurses to connect with patients' existential and spiritual dimensions. This appears to be due to inadequate explanation, insufficient mentorship and a deficiency in articulating

spirituality and spiritual care needs within the nursing curriculum (Callister et al., 2004, Yilmaz & Gurler, 2014; Timmins et al., 2014; Ross et al., 2014; Kalkim et al., 2016).

Relatively few studies were found exploring the experiences and concerns of nursing educators. However, similar challenges and anxieties were reported by nursing and other healthcare educators. These included lack of confidence, political influences on institutional policies, lack of preparedness to encounter challenges from multicultural faith systems, professional constraints, role ambiguity, work load priorities, and personal bias and experience (McSherry & Draper 1997; Timmins & Neill 2013; Prentis et al., 2014; Kalkim et al., 2016). Moreover, based on personal experiences, choice and confidence level, there were only a few educators who deliberately attempted to embrace the concept of spirituality as a legitimate item in the curriculum (Narayanasamy, 2014). Because of environmental constraints, lack of clarity in the curriculum, and personal choices, spirituality seems to have been overlooked in teaching and learning practices.

2.8.4 Knowledge and practice gap 4: curriculum structure and unprepared Faculty.

Students reported a lack of confidence in their competency and felt they had not been properly prepared by their educators to address this area (Ross et al., 2014). Also, students recognised the need to explore their own spirituality before learning to approach others (Lopez et al., 2014). Quantitative and qualitative studies have been conducted to develop knowledge about students' and educators' understanding of the place of spirituality in nursing education. Van Leeuwen and Cusveller (2004) have developed a list of nursing competencies for spiritual care. However, there is a dearth of research identifying the required competencies for nursing educators in preparing nurses competent to identify and respond to spiritual care needs (Cone & Giske, 2012). There is a deficiency in understanding how the competencies to address the spiritual care needs of patients can be developed and there is no standardised teaching practice or explicit representation of spirituality in undergraduate nursing education (Caldeira et al., 2016).

2.9 Conclusion

This literature review has identified a need to rebalance nursing education to embrace evidence for the importance of 'subjective' interpersonal meaning-based aspects of care as well as the more traditional 'objective' positivistic evidence-based approach to diseases. Nurses are not as well-prepared for the ontological role of a care provider, as they are for the tasks involved in disease

management (Benner et al., 2010). This transformation can only be achieved if nursing graduates can be enabled to develop the required competencies and motivation to understand and connect with patients in order to address spiritual care needs in a person-centred way (Rogers, 2016). Also, it requires strong nursing standards based on sound philosophical structures, to guide the curriculum structure. Nursing education and learning needs in this area need to be identified and addressed from the ontological and phenomenological perspectives of holistic nursing care (Frisch, 2003).

Chapter Three: Research Methodology

3.1 Introduction

This chapter discusses different research methodologies and why qualitative methods were preferred for this research project. The rationale for choosing case study design over other qualitative methods is presented together with a brief overview of alternative methods such as ethnography, phenomenology and grounded theory.

This chapter also discusses different types of case studies and examines how multiple case study design was identified as the most appropriate methodology for this study. Also, this chapter explains how validity and reliability are understood in this type of research design and how quality control measures were built into the research design throughout the study.

3.2 Choice of Methodology- Qualitative Methodology over Quantitative Methodology

In the following section, I will discuss the philosophical perspectives that guided the choice of qualitative methodology over quantitative methodology for this research project.

3.2.1 Epistemology and ontology

As discussed in Chapter One, epistemological and ontological perspectives form the philosophical basis for any research study in social sciences (King & Brooks, 2017). Epistemology refers to the philosophy of knowledge; *“the possible ways of gaining knowledge of social reality, whatever it is understood to be. In short, claims about how what is assumed to exist can be known”* (Blaikie, 2000, p. 8). Epistemological understanding guides us to suitable research methodology that can justify the means and resources for constructing new knowledge. On the other hand, the ontological perspective defines the nature of reality in social sciences (King & Brooks, 2017).

Social researchers may use positivistic, empirical, interpretive or constructivist methods to understand and define phenomena constituting a given social process as reality (King & Brooks, 2017). Positivism and empirical methods are generally based on deductive inquiry to study human behaviour in the given social activity. Positivistic ideas are usually based on causal effects and organised logical

premises rather than individual ideas and subjective thought processes. This establishes firm nomothetic grounds for quantitative research methodologies (Crotty, 1998; Neuman, 2003; Marczyk, DeMatteo and Festinger, 2005). The ontological framework for a positivist researcher would be based on quantifiable, observable, empirical evidence often through scientific discoveries (Bassey, 1995; King & Brook, 2017).

On the other hand, interpretive and constructivist philosophical approaches underpin qualitative frameworks. The interpretive approach recognises social reality as a relative phenomenon based on individual intuitive construction, perception and experience (Merriam, 1988; Bogdan & Biklen, 1992; Maxwell, 2006). The concepts of validity and reliability in interpretive approaches, are established by the authenticity of the selected methodology for data collection and analysis and adherence to that methodology (Ulin, Robinson and Tolley, 2004, King & Brooks, 2016). Since, objective and precise and predictive information is generally accessible through positivistic and empirical research designs, the validity and reliability of interpretive findings may be questionable from the positivist perspective. However, in qualitative research designs participants are not considered as an object of study (Casey, 1993), rather participants are empowered to explore their own intuitive constructs to define the relative meaning of perceived reality (Cohen et al., 2000). Objectivism considers reality as an independent phenomenon whereas, constructionism holds that reality is a subjective social process (Neuman, 2003). For an interpretive researcher, reality is relative (Mutch, 2005; King & Brooks, 2017). Hence, owing to the inductive nature of interpretive studies, qualitative and phenomenological studies are more appropriate to unfold the meaning-based subjective articulations in a given context (Neuman, 2003; Ulin, Robinson and Tolley, 2004). Qualitative research methodology is appropriate to enquiries about social reality (Cater & Little, 2007).

For the present study, qualitative research methodology was chosen since the focus of this study was to perform an open enquiry on how social realities were formed and perceived based on students' and nursing educators' experiences in relation to the undergraduate nursing curriculum. Epistemological reflections based on phenomenological methods enable a social researcher to understand subjective constructs and ways of seeking knowledge to apprehend reality (Kazdin, 1992, 2003a, cited in Marczyk, DeMatteo and Festinger, 2005). Hence, in order to inquire about the meaning-based

teaching and learning experiences of both student nurses and educators, qualitative methodology was chosen over quantitative methodologies (Robson & McCartan, 2016; King & Brooks, 2017).

Qualitative methodologies such as phenomenology, ethnography, grounded theory and case study designs are established research approaches rooted in the disciplines of sociology, psychology and anthropology that could be relevant to the objectives and perspectives of this research (Streubert & Carpenter, 2011). Below there is a brief description of these qualitative approaches. After due consideration of the basic purpose of the study, the nature of the research question, and the conceptual framework and sampling strategies, case study design was chosen as most appropriate (Robson & McCartan, 2016).

3.2.2 Interpretative Phenomenological Approach

This phenomenological approach explores the experiences as lived by participants and enables the researcher to inquire about the underlying structures of such experiences. Phenomenology is described as both a research philosophy and a method (Denzin and Lincoln, 2000; Lopez and Willis, 2004; Dowling, 2007). Phenomenology is rooted in a humanistic paradigm. According to Kvale:

Phenomenology is interested in elucidating both that which appears and the manner in which it appears. It studies the subjects' perspectives of their world; attempts to describe in detail the content and structure of the subjects' consciousness, to grasp the qualitative diversity of their experiences and to explicate their essential meanings (Kvale, 1996, p.53).

The Interpretative Phenomenological Approach (IPA) is originally rooted in hermeneutic tradition and deals with in-depth exploration of meaning-making discourse (Smith, 2004). IPA is widely used in health psychology and social sciences (Finlay and Ballinger, 2006) to explore the underlying conscious involvement and motives behind a person's behaviour in specific situations, rather than merely focusing on objective details (Smith & Osborn, 2008). IPA enables the researcher to explore more about what constitutes and transforms an individual being (Heidegger, 1989).

Morrison (1992) suggested that IPA helps the researcher to gain deep insights about human nature. IPA would have possibly been appropriate if the main aim was to understand how the personal values and beliefs of a nurse shaped teaching, learning and care giving practices. This approach would have enabled the researcher to explore the experiences as lived by the student nurses and educators for this study, however that would be beyond the scope of the question set for this study. Also, the focus of this research was not on human intentions or personal existential inquiry. Since, IPA did not match with the inquiry purpose, research question and conceptual framework of the study, it was not considered further (Robson & McCartan, 2016).

3.2.3 Ethnography

Ethnography involves studying the phenomenon through immersion in the given context. This qualitative method has its roots in sociology and anthropology where groups of individuals are studied within their context to discover the complexities of social process by observation (Streubert & Carpenter, 2011; Brewer, 2000). Ethnography can be used to explore health care or educational systems in a given cultural context. Data are collected through the immersion of the researcher in the real-world context (Pereira de Melo, Stofel, Gualda & Campos, 2014).

Ethnography could have been a useful approach if this research study aimed to explore the contextual complexities relating to teaching and learning aspects of spiritual care through class room teaching, seminar discussions and during clinical assessments with the researcher acting as participant or non-participant observer. However, since the focus of this study was not to contextualise and interpret the dynamics of the teaching and learning process in a specific academic culture but to develop a wider understanding how spiritual competency is addressed in undergraduate nursing courses, this methodology was also discarded. Also, immersion of researcher in the context as an observer would have been beyond the scope of this study, due to time limitation to recruit participants for such detailed observations (Robson & McCartan, 2016).

3.2.4 Grounded Theory

Grounded theory is a qualitative approach which was developed from sociological perspectives considering the research participants' experiences (Streubert & Carpenter, 2011).

The grounded theory approach allows the researcher to observe any given social phenomenon, developing deeper insight into the underlying psychosocial processes based on the participants' experiences, without preconceptions (Charmaz, 2014). By conducting practice observations and individual or group interviews, grounded theory adopts common methods of engaging participants to generate meaning directly grounded in the reality of participants' own experiences (Streubert & Carpenter, 2011). Grounded theory research uses theoretical sampling where saturation and constant comparison allow the researcher to recruit sufficient participants to make a focused exploration of the research question (Bryant & Charmaz, 2010; Charmaz, 2014). Saturation is achieved by constant comparison and when no further data can be found to develop more categories, to establish a theory based on the data collected. As a result, a theory is developed based on the data received from group participants establishing the relationship between their social roles and the context observed (Streubert & Carpenter, 2011).

A grounded theory study would have been useful if the purpose of this research was to develop a theory to address conceptual challenges based on student nurses' or educators' experiences in relation to spirituality. This methodology was discarded as inappropriate to the research question.

3.2.5 Case study

Case study designs are widely used in nursing research to explore standards of health care practices and to identify existing needs and challenges in delivery of quality care (Casey & Houghton, 2010).

Since the aim of this study was to inquire how students are prepared by nursing educators to approach spiritual care a case study design was judged to be most appropriate. Case study is distinctively useful in evaluating and exploring the nature of underlying issues with reference to an identified phenomenon (Yin 2009, 2014; Robson & McCartan 2016). The case study approach was appropriate to explore the underlying factors perceived to influence students' learning in this area. A case study approach allows the researcher to explain and explore the causal relationships of underlying determinants with real life interventions (Robson & McCartan, 2016). It enables exploration of the environmental factors influencing professional engagement for both student and educators. Case study as a research design that allows the researcher to evaluate the strengths and limitations of the subject studied in context.

Case studies can be used to enable some generalisation of the studied phenomena rather than particularising the situation to a given space, time and group (Yin, 2014). The case study approach has been defined as follows:

Case study is an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident... Case study copes with technically distinctive situations in which there will be many more variables of interest than data points and, as one result relies on multiple sources of evidence with data needing to converge in a triangulating fashion, and as another result benefits from the prior development of theoretical positions to guide data collection and analysis (Yin, 2014, p.17).

The research aimed to gather evidence from student nurses, nursing educators and curriculum documents to explore how spirituality is integrated in nursing education and what is the relationship between these data sources in each case. Yin's definition fitted in with my research question as it allowed me to investigate all these three areas in depth and to explore underlying factors.

Several approaches to conducting a case study can be found in social and health sciences (Stakes, 2000; Yin, 2014; Robson & McCartan, 2016). The following section explains my choice of an exploratory multiple case study design proposed by Yin (2009, 2014) rather than other possible case study methods.

3.2.5.1 Types of Case Studies

Yin (2009, 2014) provided a structured and comprehensive approach to using case study design. According to Yin (2009, 2014), there are four types of designs for case studies. These are, single case (holistic) design, single case (embedded) designs, multiple case (holistic) designs and multiple case (embedded) designs. A single case study is conducted where a critical or specific case has to be examined as a representative case. A single case study is holistic when the unit of study is approached as a whole. If there are sub units selected to be studied within a single case study, this is known as an embedded case study design. If a study examines more than one single case, it is

designated a multiple case studies design. A single case study could also be used as a pilot case study before conducting multiple case studies.

Multiple case studies can also be holistic or embedded in nature, focusing on the whole unit or various sub units in its each case. In multiple case studies, cases can be selected for literal replication (similar findings) or theoretical replications (contrasting results). To develop a replication strategy, a theoretical framework is required. According to Yin (2009 p. 54) a *“theoretical framework should state the conditions under which a particular phenomenon is likely to be found (literal replication) as well as the conditions when it is not likely to be found (a theoretical replication)”*. Yin, also describes that once the theoretical framework is developed then individual cases should be identified to follow the specified research design and data collection process. In multiple case studies, each case study finding guides the conclusion and addresses the nature and scope of pre-set propositions.

Case studies could also be classified as intrinsic, instrumental or collective (Stakes, 2000). A case study could be intrinsic if it related to the interest of the researcher, not what a case may illuminate. On the contrary, an instrumental case study design allows the researcher to identify and investigate the case in order to provide more insight regarding the situation studied. For an instrumental, case study the researcher finds purposive cases that can best explore the particular research question. Collective case studies are used to study a number of cases so that results and findings could be compared (Creswell, 1998). The present study could be described as both instrumental and collective. Using a multiple case study design was judged to be most appropriate to explore the underlying challenges of integrating spiritual care ideas in nursing education. As instrumental case study approach allows the researcher to focus on a specific inquiry and the case provides the overall understanding to explore the underlying issue (Creswell, 1998). A case, in a case study could be an individual, an event, an entity or an organisation (Robson & McCartan, 2016). For this study, each case was a university, where an undergraduate nursing programme was offered. A case may reveal variation in programmes offered, diverse perspectives from the stake holders and variety in programme components and the basic framework or philosophy of the course. For this study, the stakeholders were the student nurses, nursing educators and the programme components were the

curriculum documents. These were used as the basis for designing an instrumental case study (Creswell, 1998).

Multiple cases were approached to inquire about the level of integration, perceived challenges and barriers with reference to spiritual care in undergraduate nursing education. Multiple case studies enable more compelling and robust evidence to be gathered. The rationale was based on considering literal replication and constructing internal and external validity using a qualitative methodology, which is unique to Yin's (2009, 2014), case study design. Yin's case study approach is discussed below in detail.

3.3 Case study design

"A research design is the logic that links the data to be collected and the conclusions to be drawn to the initial questions of the study" (Yin, 2014, p. 26).

An exploratory multiple case study design was chosen to investigate critical causal relationships among the findings and the underlying determinants that were underexplored to date (Yin, 2009, 2014). The case study design is a *"logical model of proof that allows the researcher to draw inferences concerning casual relations among the variables under investigation"* (Yin, 2009, p.26). Exploratory multiple case study designs could allow the researcher to establish a causal relation among the factors that influence the level and extent of integrating spirituality in nursing education; rather just describing or explaining the issues as necessary information (Robson & McCartan, 2016). Thus, to investigate how spirituality is integrated in undergraduate nursing education, an exploratory multiple case study design was judged to be the most appropriate research methodology to explore:

- a) Approaches used by each case to relate spirituality in nursing education
- b) Any teaching strengths and innovative learning practice used by the case
- c) Challenges identified by students in each case
- d) Challenges identified by educators in each case
- e) Curriculum structure in relating the ideas of spirituality to course content

It was hoped that an exploratory multiple case study design would enable the researcher to suggest causal relations amongst these findings within and across all cases.

According to Yin (2014, p. 29), for a quality case study design, it requires:

1. A study question
2. Related proposition
3. Units of analysis
4. A Logic of linking data to the proposition
5. Specified criteria for data interpretation.

3.3.1 A Study Question

For this study the research question, as mentioned earlier in chapter one was:

How is spirituality integrated in undergraduate nursing education in England?

The rationale for developing this research question along with the study aims and objectives are discussed in Chapter One.

3.3.2 Propositions

Proposition are the markers that direct the nature and scope of inquiry and keep a researcher focused to inquire about the research question (Yin, 2014). Based on the identified gaps and issues affecting the integration of spirituality in nursing education, as discussed in Chapter Two; the following propositions were identified for this study:

1. There are conceptual barriers and gaps in relating spirituality in nursing education, due to which spiritual care aspects are currently neglected in nursing training and practice.
2. Student nurses recognise the need for adequate support from educators to develop confidence and competency in approaching spiritual care aspects.
3. Nursing educators lack confidence and training in this area. Views and concerns from nursing educators on integrating spirituality in nursing education are under-investigated
4. The nursing curriculum does not explicitly integrate spiritual care into nursing knowledge and practice.

3.3.3 Unit of Analysis

Yin (2009, p. 30) defines units of analysis as, “*the same as the definition of the case*”. Units of analysis are focused around the key objectives set as research questions (Casey and Houghton,

2010). Units of analysis distinguish the identified group or persons within each case, from the outside context to establish the focus on the research question (Yin, 2009). For this study, as the main objectives were to inquire about the teaching and learning practices and perceived gaps in knowledge and competency development with reference to spirituality and nursing education, each case (course) was designated as a unit of analysis. Within each unit of analysis nursing students, educators and the curriculum itself were studied in to elucidate the propositions.

3.3.4 Linking the gathered data with literature review and identified propositions

The identified propositions were linked with the literature review (Chapter Two). The rationale for this is briefly developed below, proposition by proposition. Data based on research findings in each case will be further linked in Chapter Eleven, to help establish the validity of the research (Yin, 2009).

Proposition 1:

There are conceptual barriers and gaps in relating spirituality in nursing education, due to which spiritual care aspects are currently neglected in nursing training and practice.

Findings from Literature review:

Students reported a lack of confidence in their competency and felt they had not been properly prepared by their educators to address this area. Also, students recognised the need to explore their own spirituality before learning to approach others (Lopez et al., 2014; Ross et al., 2014).

Proposition 2:

Student nurses recognised the need for adequate support from educators to develop confidence and competency in approaching spiritual care aspects.

Findings from Literature review:

Due to environmental constraints, lack of clarity in the curriculum, and as a result of educators' personal choices, spirituality was often overlooked in teaching and learning practices (McSherry & Draper 1997; Timmins & Neill, 2013; Kalkim et al., 2016).

Proposition 3:

Nursing educators lack confidence and training in this area. The views and concerns from nursing educators on integrating spirituality in nursing education are under-investigated.

Findings from Literature review:

Competencies and support required to nursing educators in preparing nurses to identify and respond to spiritual care needs are not well explored (Cone & Giske, 2012, Caldeira et al., 2016).

Proposition 4:

The nursing curriculum does not explicitly integrate spiritual care into nursing knowledge and practice

Findings from Literature review:

Inadequate explanation about relating spiritual care to practice, insufficient mentorship by nursing educators and inadequate emphasis on spirituality and spiritual care needs within the nursing curriculum was reported by nursing students. (Callister et al., 2004, Yilmaz & Gurler 2014; Timmins et al., 2014; Ross et al., 2014, Kalkim et al., 2016).

3.3.5 Specified criteria for data interpretation.

Validity and reliability, in interpretive approaches, are defined by the authenticity of the selected methodology for data collection and analysis (Ulin, Robinson and Tolley, 2004). However, there are certain criticisms raised when considering case study as a research method. The major criticism concerns reliability. Robson & McCartan (2016) alleged that the case study method over-simplifies and exaggerates findings based on selective or limited interpretation of the data, influenced by the researcher's pre-conceptions. Others have criticised the case study method as unscientific and opportunity-based, providing only a partial view and therefore not capable of supporting conclusions that can be applied more generally (Blaxter et al., 2006).

Terms of reliability and validity are relevant in establishing the quality and robust findings in qualitative research and particularly in case study design (Yin, 2014; Robson & McCartan, 2016). By following the research protocol (Yin, 2009), reliability and validity were established throughout the data collection and analysis phase. To establish validity Yin proposed four tests that can establish credibility of case studies as a recognised method of qualitative enquiry in social sciences (2009, p. 41; 2014, p. 45). These measures are as follows:

3.3.5.1 Construct validity

According to Yin (2009) to achieve construct validity in case studies, rigorous data planning, collecting and analysis is required. Yin proposed that in order to establish construct validity, careful planning to collect multiple sources of evidence within each case was necessary. Such planning and multiple approaches to data collection, enable data triangulation which affirms the authenticity and construct-validity of a case study finding. Triangulation helps the researcher to develop data convergence based on a variety of sources of information (Creswell, 1998). By rigorous data collection methods using multiple techniques and data triangulation the quality of a case study design can be assured (Yin, 2014; Robson & McCartan, 2016). In this research, different methods including semi structured interviews, focus group studies and document reviews were used to maintain the rigour and authenticate the validity of findings using data triangulation. The details and rationale of choosing multiple data collection methods for this research and the process of data triangulation will be further discussed in Chapter Four.

3.3.5.2 Internal validity

Internal validity is “*the strength of a cause - effect link made by a case study*” (Yin 2014, p. 239). Internal validity determines the nature of underlying causes and their relationship to the findings, to justify the uniqueness of each case. Case study tactics relevant to internal validity include pattern matching, explanation building for each case, addressing rival explanations and logical models to explain the findings. As Yin (2014, p.143) explains:

For a case study analysis, one of the most desirable techniques is to use a pattern matching logic. Such a logic (Trochim, 1989) compares an empirically based pattern - that is, one based on the findings from your case study-with a predicted one made before you collected your data (or with several alternative predications) ...If the empirical and predicted patterns appears to be similar, the result can help a case study to strengthen its internal validity.

To establish internal validity, data from each case was analysed using a template analysis approach. The process of template development and data analysis is discussed in Chapter Four (4.2.5.1). By using template analysis similar and contrasting patterns were identified for any rival explanation. Rival explanation is a possible alternative finding that is different from the initial propositions set for the case study (Yin, 2014). A summary of each case discussing the rival explanations was developed to signify the exclusiveness of each case and present the internal validity. Using template analysis, a

logic model based on themes and sub-themes was developed for each case (King & Brooks, 2017). The process has been explained in depth in Chapter Four (4.3.1). Chapter Five discusses Case Study A; Chapter Six presents Case Study B and Chapter Seven Case Study C. Chapters Eight-Nine present data collected from incomplete cases D, and E.

3.3.5.3 External Validity

“The extent to which the findings from a case study can be analytically generalised to other situations that were not part of the original study is known as External validity” (Yin 2014, p.238). Yin (2009, 2014) conceded that for single case study, external validity was a challenge. In the present study, external validity was achieved using replication logic and multiple case studies. The limitation of findings based on the interpretation of data from a single case was mitigated by taking a small group of cases. This enabled the researcher to conduct a richer analysis looking for replication between cases but also taking note of contrasting findings. The process is discussed in depth in Chapter Four that covers how data was interpreted and themes established using the template analysis approach (King & Brooks, 2017). Chapter Nine presents the cross-case synthesis to establish the external validity of the three main case studies.

3.3.5.4 Reliability

A consistent and repeatable approach of the research procedures determines the reliability of a case study (Yin, 2014). Yin suggested the use of a case study protocol to develop case study data enhanced the reliability of research findings. The study protocol should include the following (Yin, 2009, p.81):

- 1. An overview of the case study project:** (This includes project aim and objectives and relevant reading about the topic to be investigated).

For establishing reliability of this study, detailed discussion on the research aim, objectives and rationale and scope of the study has been presented in Chapter One. To establish the importance of the research question, a literature review from 1993-2017 is discussed in Chapter Two.

- 2. Field procedures:** (Presentation of credentials, access to case study sites, sources of data are important in maintaining reliability of a case study).

For this research, ethical approval was sought from the host university and multiple case sites.

Accessing and recruiting participants involved email correspondence between undergraduate programme leaders, course administrators, educators and students; informing them about the research project. Also, a small power point presentation was delivered to orient potential participants to the aims and scope of the research project. Multiple sources of data were used, including semi structured interviews with nursing educators, focus groups with students and curriculum review of the undergraduate nursing courses. The details about field procedures covering, ethics approval, access issues, recruiting, and modes of data collection are discussed in detail in Chapter Four.

- 3. Case study questions:** (Specific questions and potential sources to be identified to seek information and plan research).

Yin's reliability framework emphasises questioning the case at different levels. Since the aim of this study was to inquire how spirituality is integrated in nursing education; multiple sources of information including curriculum, students and educators were required to investigate the issue. Hence, separate information sheets (Appendix 3 for student nurses and Appendix 4 for nursing educators) were developed to access potential participants for the study. Also, separate interview guides were developed for conducting interviews with educators (Appendix 7) and focus groups with student nurses (Appendix 8). The detailed discussion on conducting interviews, focus group studies and document reviews is presented in Chapter Four.

The process of pattern-matching during cross-case synthesis and relating it to the gaps identified in the literature review is discussed in Chapter Twelve and is illustrated in Appendix 11.

- 4. A guide for the case study report:** (Outline for the data, use and presentation of other documents).

Separate folders were developed to keep progress records for each case. This included keeping a log of emails, correspondence, the time frame used in ethics clearance and in accessing and recruiting participants. Data collected from each case in the form of recorded interviews and documents accessed for curriculum review; was kept anonymous and confidential following university and legal

data protection guidelines. These measures helped by keeping an audit trail and avoiding any bias in performing data analysis (Yin, 2009, 2014). Chapter Four discusses all steps taken for data collection in detail.

3.4 Chapter Summary

Various qualitative approaches could have been used to conduct this study. However, the nature of the research question established the best methodology for this study. This chapter identified the limited scope of other qualitative approaches compared with case study design in addressing the research question. Furthermore, this chapter explained different types of case studies and highlighted the scope of exploratory multiple case studies for this research. Finally, based on Yin (2009, 2014) case study design, each step towards a successful case study design was explained and related to the study plan.

Chapter Four: Research Methods

4.1 Introduction

This chapter discusses how the research protocol was carried forward as field proceedings suggested by Yin (2009, 2014) and discussed in Chapter Three. This chapter discusses the entire process of data collection and analysis in depth. Several stages were involved in the data collection process. These included obtaining ethical approval, accessing and recruiting study participants and establishing validity and reliability throughout data collection and data analysis for quality control. However, there were difficulties and challenges at each stage. The chapter explains the nature of problems faced at different stages, particularly during data collection and how those issues were addressed constructively.

4.2 The Research process

The research process included several stages as follows:

1. Seeking Ethics approval
2. Sampling
3. Data collection
4. Data Analysis

The entire research process along with the challenges faced at each stage is discussed below. Professional development approaches that were used as constructive responses to highlighted difficulties are also discussed. Adaptability and reflexivity were applied and evidenced at each stage to assure the quality and rigour of this study (Yin 2009, 2014; Robson & McCartan, 2016).

4.2.1 Seeking Ethics Approval

To initiate the research study Ethical approval was sought from the school Research and Ethics Panel (SREP), University of Huddersfield (Appendix 2). Research Ethics approval included assessing potential ethical, health and safety risk assessments to assure data protection and safeguarding, as presented in Appendix 2 (Blaxter et al., 2006; Yin, 2009). Policies regarding intellectual property,

plagiarism, privacy, taking informed consent and disclosure were followed (Yin, 2009). Separate information sheets were developed for nursing students and educators to provide an overview about the aims of this study (Appendix 3 and 4). In addition to the ethics approval from the primary university, ethical approval was also sought from the other universities involved in the study (Appendix 2).

However, there were difficulties and delays in recruiting the planned sites and this also delayed final ethical approval. The delayed access and unpredictable response from potential field sites can influence the aims and scope of research study and can be a demanding and continuous process (Blaxter et al., 2006). Hence, a constant effort was made to explore potential opportunities (Blaxter et al., 2006; Yin, 2009) at different universities across England.

Preliminary approaches were made to a number of universities across England. But owing to study schedules and reluctance to ask students to participate in too many research studies, this project did not get the required attention. In many cases, no responses or apologies were received from programme administrators when the initial invitation was sent to potential sites. To access potential field sites, several options were explored by the researcher (Blaxter et al., 2006; Robson & McCartan, 2016). Along with institutional emails, a call for participation from nursing educators across English universities was made using Research Gate; as a social media resource. Using appropriate social media can be a valuable strategy to call for voluntarily participation; as it allows disseminating information and seeking response from a wider audience. It is less time and effort consuming and can be useful, if timely responses are made, to negotiate further research plans (King & Brook, 2017). However, no response was forthcoming. Various invitations through emails were sent to faculty members and heads of nursing education departments of thirteen universities. Five universities responded, expressing their interest in research participation subject to the provision of local ethical approval. There were occasions, where the administrative and academic support was there but university ethics committees wanted to see the SREP review from the home university. Hence, a revised approval was sought to fulfil the ethics related approval requirements from all potential participant universities (Appendix 2).

It took sixteen months to identify potential field sites and seek ethical approval from all potential universities. A chronological account of the process is summarised in Table 1.

Table 1: Summary of the process for Seeking Ethics Approval

Stage	Seeking Ethics Approval	Milestones achieved
1.	Contacting heads of departments of the potential universities across England to invite for the study x 13 universities	Dec 2013 Oct 2015
2.	School Research Ethics Panel (SREP) approval. Re application	Jul 2014 Aug 2015
3.	Approval from University Ethics Committees Case A	Jul 2014
4.	Approval from University Ethics Committees Case B	Jan 2015
5.	Approval from University Ethics Committees Case C	Sep 2015
6.	Approval from University Ethics Committees Case D	Sep 2015
7.	Approval from University Ethics Committees Case E	Oct 2015

Seeking ethics approval from all potential field sites was a long and tedious process due to the different ethical review policies of each university and the availability of ethical review panel members. That time was used constructively, by keeping an audit trail of all processes, including a record of correspondence via email from different universities. This allowed the researcher keep a time track and reflect on the issues that might relate the context to the findings (Blaxter et al., 2006; Yin, 2009; Robson & McCartan, 2016). The process of reflexivity involved is discussed further in Chapter Twelve.

Presenting research for peer debriefing and support are considered highly relevant in qualitative research to avoid personal bias and evidence the validity of research findings (Robson & McCartan, 2016). With a shared understanding and encouragement from my supervisory team, the time was utilised for professional development in research methodologies useful to conduct research and data analysis. Based on the initial literature review, I developed a manuscript published in an indexed and peer reviewed journal (*International Journal of Multidisciplinary Comparative Studies* Vol 2 No.1, 2015, pp.7-31). In addition, oral presentations on the literature review were delivered at various

conferences (International Conference on Comparative and Multidisciplinary studies in Social and Human Sciences, Sept 2014 and IJAS (International Journal of Arts and Sciences international conference, Nov, 2015). The details of each research output are presented in the beginning of the thesis for further reference.

4.2.2 Sampling

For multiple case studies, the logic of selecting multiple case sampling is not based on identifying any prevalence of the inquired phenomenon. Rather, the logic of identifying multiple cases is based on finding similar or contrasting underlying aspects of the situation studied. The resultant findings enable comparisons to be made and the extent and type of replication found, enables some conclusions to be drawn about common and unique characteristics across multiple cases (Yin, 2009, 2014).

For this, opportunity or convenience sampling was used to select five universities where an undergraduate nursing programme was offered across England. The selections were made on the basis of who responded first, showing interest and availability within the limited time set for recruitment (Robinson, 2014). Due to the challenges mentioned in section 4.2.1, the sampling was based on convenience to avoid further delays in recruitment, considering the limited time frame for the PhD project.

These schools of nursing, represented five different geographical, historical and cultural contexts in England. This enabled the researcher to examine underlying variations in the approach to education around spirituality in nursing and the inclusion (or exclusion) of spirituality as part of core and clinical teaching. This variation restricted generalization to a local level to avoid abstract decontextualization, which could have affected the reliability of this research (Yin, 2014). Different learning environments, academic culture, curriculum structures and institutional priorities were found in the cases studied and this supports the external validity of the study by using replication logic across multiple case studies, (Yin, 2009, Robson & McCartan, 2016).

4.2.2.1 Accessing and recruiting participants:

As discussed in Chapter Three, to develop construct validity and reliability, a research protocol was developed. Information about the project was disseminated well in advance to give participants sufficient time to plan their availability for the project (Yin, 2009; Robson & McCartan, 2016).

After identifying potential cases as described above, formal permission was sought from Deans or Heads of School to carry out the study (Blaxter et al., 2006). Once, the initial permission was granted, communication with related programme coordinators and programme heads was started by approaching all nursing educators teaching in undergraduate nursing programmes and student nurses, interested in exploring issues related to integrating spirituality in nursing education. Also, a ten-minute presentation was scheduled with nursing students to introduce the research aims and scope of the study. A small power point presentation was developed to specify the nature of research and the aims behind conducting the focus group study with students (Appendix 5). The talk was scheduled after receiving permission from the course leaders across the five identified cases.

After getting replies from interested participants including both educators and students, via email and telephone, potential interviewees were approached via email. A brief outline detailing the nature and purpose of this research was shared with departmental heads. After receiving responses from interested participants, an information sheet, along with a formal consent form was sent via email. The information sheet included the possibility of a telephone conversation to clarify any issues before a decision to consent for the research study. All participants were given the information and consent sheet one-month prior to scheduling interview dates and time so that participants could reflect on the necessary and relevant information to explore any potential sensitivities on personal level; before signing the informed consent (Blaxter et al. 2006; Yin 2009). A copy of each document developed is appended, including separate information sheets for nursing students (Appendix 3), nursing educators (Appendix 4), power point presentation (Appendix 5) and consent form (Appendix 6) for the introductory talk to nursing students.

The process of recruitment was not as simple as had been hoped due to students' limited availability during clinical placements or exam schedules. Due to academic involvement, accessing nursing educators for 1:1 interviews was a challenge too. After the long process of gaining ethical approval to access participants from the five universities, getting an inadequate response from nursing educators and nursing students could have affected the rigour and validity of findings (Yin, 2014; Robson & McCartan, 2016). There were universities where recruiting participants was facilitated by the head of departments and course leaders which resulted in very active and timely schedules.

Hence, various adaptation and flexible planning was offered to departmental heads, nursing programme administrators and to participants (where allowed); to negotiate accessibility options when participants could be less busy (Blaxter et al., 2006; Richards, 2015; Robson & McCartan, 2016).

There were instances, where educators were interested to be part of the study but could not meet the researcher on face-to-face, hence the alternative option of skype interviews was offered (Hanna, 2012; Robson & McCartan, 2016). Also, there were occasions, where despite early commitments by the students, focus group studies had to be rescheduled due to last minute disappointment where no or only one student turned up. However, regardless of such challenges and disappointments, reasonably complete data sets were obtained for three cases. Table 2 presents a Case Specific Summary of the Challenges faced during accessing and recruiting participants.

Table 2: Case specific Summary of challenges

Case	Initial contact with the department/ Heads	Access to Nursing Educators	Access to Nursing students	Introductory session with students
A	Aug 2014	Oct 2014- Nov 2015	Oct 2014- Nov 2015	1. Nov 2014 2. Oct 2015
B	Jan 2015	Jan-May 2015	May 2015	May 2015
C	Sep 2015	Oct -Nov 2015	Oct-Jan 2016	Not required
D	Sep 2015	Nov 2015	Nov 2015- Jan 2016 No Response- Recruitment Declined	Nov 2015
E	Oct 2015	Nov 2015- Jan 2016 No Response- Recruitment Declined	Nov 2015- Jan 2016	Declined

4.2.3 Data Collection

The following methods were used for the data collection.

4.2.3.1 Document Review

Document review is an important qualitative research method (Bowen, 2009). Documents are formal communications with a specialised knowledge base and policy framework (Bauer, Gaskell, & Allum, 2000). Documents are stable and provide exact evidence of references or details of events that could be reviewed repeatedly. They may include, letters, personal notes, and email correspondence, a report of events, proposals, internal records or articles (Yin, 2009, 2014). Documents are considered “un-obtrusive and un-reactive” as they do not get affected by being observed by a researcher (Robson & McCartan, 2016, p. 349), yet can be strong evidence to support or validate the data findings generated by using other inquiry methods. However, documents may not clarify the level of personal engagement and extent of group contribution in developing or utilising the document as a resource (Robson & McCartan, 2016). Also, document analysis requires interpretation from the researcher who reviews the document using analytic strategies (Finnegan, 1996). Those review strategies include selecting and considering relevant documents to approach and understanding the relative social context and its production requirements (Bowen, 2009; Atkinson et al., 2001).

For this study, content analysis was used as a technique to review the documents. Content analysis focuses, *the frequency with which certain words or particular phrases occur in the text as a means of identifying its characteristics* (May, 2001 p. 191). Content analysis could be applied with both quantitative and qualitative data analysis (Robson & McCartan, 2016). It is a flexible method that allows researcher to develop inferences based on the presence, frequency or relation of the specific word, term or phrase within the text (May, 2001). For this study, content analysis included BSc year 3 nursing curricula focusing on the term spirituality or spiritual care needs. Also, some descriptive words and associated phrases with the concept of spirituality such as, holistic care, compassion, hope belief and person-centred care etc., reflected by the key definitions discussed in Chapter Two; were used to review the curriculum documents. The purpose of performing content analysis was to inquire in what ways and to what extent, the term or the concept of spirituality was integrated in curriculum documents.

Content analysis could also be useful evidence for data triangulation to construct internal validity. By supporting findings based on the data gathered from nursing educators and students in each case,

curriculum review could be a valuable resource to validate the strength of the data from multiple resources and enrich the case study database (Yin, 2014). The documents discovered in seeking to access information about the undergraduate nursing curriculum in each case are summarised in Table 3.

Table 3: Case wise summary of accessing curriculum and documents reviewed

Case	Curriculum Access granted/Declined	Documents received and reviewed
A	Granted	-Various Course grids for BSc Yr. 3 nursing courses -Handbook for assessment criteria
B	Granted	-Various Course grids for BSc Yr. 3 nursing courses -Handbook for assessment criteria
C	Granted	-Undergraduate Programme guide.
D	Granted	-Various Course grids for BSc Yr. 3 nursing courses -Specialised course template developed for teaching spirituality both for face-to-face learning and blended learning courses
E	Declined	-

4.2.3.2 Interviews

The interview method is highly recommended when the focus of the study is to explore the meaning associated with a particular phenomenon. Interviews are also useful if the purpose of the study is to explore multiple perspectives on the same issue by conducting a series of interviews, in the given context (Blaxter et al., 2006; Robson & McCartan, 2016). For this study one part of the research agenda was to explore underlying issues faced by nursing educators in addressing spirituality in nursing education. Semi-structured 1:1 interviews were chosen as the most appropriate method for data collection from the educators. This allowed the researcher to identify and discuss individual educators' views on the issues. Conducting a series of interviews within each case, enabled the researcher to relate educators' experiences in a given case, contributing to internal validity (Yin 2009, 2014). The interview method allowed the interviewer to understand, explore and clarify concerns with

the interviewee; which could not be achieved through a questionnaire or direct observation (Boyce & Neale, 2006).

Semi-structured interviews were conducted with nursing educators using a focused guide (Appendices 6 and 7), as a standard way of data collection across the identified cases (Yin, 2009; Robson & McCartan, 2016). Semi-structured interviews allow both flexibility and focus while approaching interviewees. As compared to fully structured interviews, semi structured interviews are not too rigid or question oriented only. Having a pre-determined set of questions and areas to be addressed enabled the researcher to modify the pace and questioning technique based on the interviewee responses or explanations, in semi-structured interviews. Unlike unstructured interviews, semi-structured interviews facilitate flexible yet focused and formal conversations between interviewer and interviewee (Robson & McCartan, 2016).

In addition, for convenience sampling, recruiting participants based on their availability may limit the variety of responses based on different experiences and may challenge the credibility of the research (Malterud & Siersma, 2015; Richards, 2015). This means more interviews and other relevant data are needed to reduce biased interpretations and assure robust findings (Richards, 2015). To maximise the number of nursing educators willing to participate they were given options of either face-to-face or skype interviews (Robson & McCartan, 2016). Also, in qualitative research the information power lies within the quality of the interview process. A strong and clear communication between the researcher and the participants relevant to the studied phenomenon improves the information power compared with an ambiguous and unstructured interview process (Malterud & Siersma, 2015). Hence, an interview guide was developed after seeking approval on it through the peer review process from the senior research team members and fellow researchers. This exercise helped ensure the validity and credibility of the data collection tools (Yin, 2009; Malterud & Siersma, 2015; Robson & McCartan, 2016).

Interview questions were kept open-ended with pre-set questions to be asked (Yin, 2009). The recruitment criteria for conducting interviews were as follows:

- a. Nursing educators for undergraduate nursing programme from the identified case

- b. Either involved in curriculum development or direct teaching in undergraduate nursing programme.

Altogether, 13 semi-structured in-depth interviews from nursing educators with an average duration of 40 min were conducted to seek deep exploration of the nature and variety of perspectives on integrating spirituality into nursing education.

Initially, it was only planned to conduct face-to-face interviews. However, due to the delays in accessing approval of each case and then recruiting the desired number of research participants, Skype interviews were also included as a flexible option for nursing educators to maximise their participation (Creswell, 1998; Robson & McCartan, 2016). Skype interviews are considered effective alternatives for qualitative data collection (Hanna, 2012; King & Brooks, 2017). They may lack some of the features of face-to-face interviews such as physical interaction. However, they provide adequate information and were used to deal with last minute disappointments from the research participants or inability to participate in face-to-face interviews due to their busy schedules (Hanna, 2012). Skype interviews were scheduled as an alternative research medium to ensure maximum flexibility and availability of the nursing educators (Creswell 1998; King & Brooks, 2017).

Specific details regarding the time duration and mode of interview for each case are given in Table 4.

Table 4: Case A- Interviews with nursing educators

Participant identification	Interview type	Duration
1.	Face-to-face	1 hour
2	Face-to-face	55 min
3	Face-to-face	45 min
4	Face-to-face	30 min
5	Face-to-face	40 min
6	Face-to-face	45 min

Table 5: Case B- Interviews with nursing educators

Participant identification	Interview type	Duration
1.	Face-to-face	40 min
2	Face-to-face	35 min

Table 6: Case C- Interviews with nursing educators

Participant identification	Interview type	Duration
1.	Skype interview	1 hour
2	Skype interview	55 min
3	Skype interview	45 min
4	Skype interview	1 hour

Table 7: Case D - Interviews with nursing educators

Participant identification	Interview type	Duration
1.	Skype interview	1 hour

Table 8: Case E- Interviews with nursing educators

Participant identification	Interview type	Duration
0	-	-

For the Face-to-face interviews, a venue was booked in advance and participants were informed and reminded by email (Creswell, 1998). When Skype interviews were planned, a quiet room with adequate light and internet access was booked. Email addresses for accessing skype accounts were checked by exchanging test messages a week prior to the interviews to avoid any inconvenience on the scheduled interview day (Hanna, 2012). Participants who volunteered for the study were given the information sheet prior to interview to allow them to check in advance that they were comfortable with the study aims (Richards, 2015). All necessary information regarding interview recording, data protection and the relevant data collection process, including confidentiality and the planned future process of research dissemination were also discussed prior to interview. Once agreed to start and after taking both verbal and written consent for the study, interviews were conducted and recorded using electronic digital recorders (Creswell, 1998).

All policies regarding privacy, data protection, risk assessment and health and safety measures, according to the university research guides, were followed. The data were anonymised and protected during the process of data transcription and data analysis (Blaxter et al., 2006; Robson & McCartan, 2016).

4.2.3.3 Focus group study

Focus groups are used to explore multiple experiences and views from identified group participants (Morgan, 1988; Jayasekara, 2012), who have a certain common interest or characteristic to be part of that identified group (Krueger, 1994). By skilful conduct of a group addressing a pre-defined topic, discussion, exploration and insights are generated among the group participants, which may not be achieved from individualised and isolated interviews (Kitzinger, 1994; Morgan, 1997). Also, focus group methodologies are considered to offer 'the phenomenological aspects of the real-life experience' that controlled experiments could not achieve (Merton, 1987, p. 558). The flexibility and groups dynamics generated through focus groups are rooted in a creative approach to data collection from several participants at the same time. By generating a collective interest and focus on the desired aspect of the research inquiry a variety of views can be assessed and shared at the same time. Focus groups can also empower individual participants by developing stimulation from listening and sharing views from other participants on difficult topics (Robson & McCartan, 2016). However, if the group dynamics are not facilitated by the researcher conflicts among participants may arise due to power struggles, dominance of one view over another and issues of confidentiality (Robson & McCartan, 2016). It is important for the researcher to develop expertise in moderation of groups in order to generate healthy group dynamics. This can be achieved by establishing control and providing a supportive environment where different viewpoints can be expressed and adequately recorded in the given time (Marshall & Rossman, 2006). A focus group with final year nursing students was carried out for each case, so that their overall learning and practice experience could be understood.

Each focus group was conducted in a pre-booked room. A room with the capacity for 6-10 students with an electric socket for the recording devices, was requested by the researcher. The venue was visited prior to the focus group study to check lighting and electric sockets availability. Also, chairs were arranged in circle to enable constructive discussion (Blaxter et al., 2006). A note saying, *focus*

group study for BScN year 3 students, please do not disturb was posted on the door to avoid any confusion or disturbance during the study. Participants were both informed and reminded through email notifications. Participants who volunteered for the study were given the information sheet prior to interview to enable them to raise any queries in advance (Robson & McCartan, 2016).

All necessary information regarding interview recording, data protection and the relevant data collection process, including confidentiality and the future process of research dissemination was discussed prior to the focus groups (Marshall and Rossman, 2006). After taking both verbal and written consent for the study, discussion was initiated using an interview guide developed for the focus group study. The interview guide enabled the researcher to have clarity about the topic(s) to be covered during the group discussion. This enabled a focused yet flexible, mutually supportive, engaging and stimulating environment to be provided to all participants. White board, personal memos and diary notes were also used to note main points during the sessions (Blaxter et al., 2006). Use of white board allowed the researcher to keep a log of important points that were identified during the focus group study so that more clarity and focused discussion could be generated covering relevant themes, in the set time limit (Marshall & Rossman, 2006; Blaxter et al., 2006). Diary notes along with the audio recording of the focus group study, were very useful in complementing the evidence gathered during the study. It enabled the researcher to highlight or record any particular observation during the discussion which might not be apparent in the audio recording. These notes were useful in recording findings based on the researcher's observations during the group discussion (King & Brooks, 2017). Further discussion on using diary notes and how they were found useful in developing reflexivity is presented in Chapter Eleven.

Table 9. Illustrates the number of students who participated in each case and the duration of each focus group study.

Table 9: Case wise summary on focus group studies

Case no.	No of students in each focus group study	Time Duration
A	4	1 hour
B	7	1 hour
C	4	1hour 15 min
D	0	-
E	2	30 min

4.2.4 Data Protection

Data were collected using digital recorders to keep it in a safe, systematic and manageable folder (Richards, 2015). All files were kept anonymous and stored in password protected computer drives (Blaxter et al., 2006, Richards, 2015). Transcriptions of recorded data were made by the researcher and stored confidentially and anonymously. All electronic copies were saved on password protected computer drives and the hard copies were kept in a locked filing cabinet, in compliance with data protection standards and guidance of the University of Huddersfield and the British Educational Research Association (BERA, 2011).

4.2.5 Health and Safety Issues

During university working hours, rooms were booked in respective university premises to conduct interviews complying with gender and safety policies (University of Huddersfield, 2011; British Educational Research Association, 2011). Subjects were also reminded of the support available through their institutions in terms of professional help, if required (Marshall & Rossman, 2006). The risk assessment form was also submitted as part of the ethics review application.

4.2.6 Limitations of the study

There were obvious difficulties in accessing cases and recruiting participants for conducting interviews, focus group studies and curriculum review, which are evident in all the above tables. Out of five identified cases, approved by the ethics committee, only three cases had provided a complete data set by February 2016. Since the case recruitment process was initiated in December 2013, it

was a long three years' period of approaching potential cases and striving to access the required number of participants both for semi structured interviews and focus group studies.

Despite repeated reminders, individual invitations and offering flexible options of face-to-face or skype interview, not enough positive replies were received from nursing educators for cases 4 and 5. For the focus groups, although students showed interest in participating at the recruitment phase, there were last minute apologies for both these cases, too. Rescheduling these focus group studies proved impossible due to the already extended time line from the university ethics committee along with the limitations on the investigator's time, within the planned time frame for the study.

There was limited access to participants and curriculum for Case Four and Five, which is summarised as follows in Table 10.

Table 10: Overview of Incomplete Cases- (UD and UE)

Case.	Response from Nursing educators	Response from Nursing students	Curriculum Access
D	1	0	Yes
E	0	2	No

4.2.7 Data Transcription

The data were recorded using digital voice recorders with back up battery power to avoid any data loss due to power failure (Blaxter et al., 2006; Richards, 2015). The interviews and focus group discussions were transcribed by the researcher. Template analysis was used as an approach for data analysis. Data were coded using the software NVIVO (Richards, 2015; King & Brooks, 2017).

To maintain confidentiality and data protection, separate folders were developed for each case file, saved with pseudonyms and an identifier for the type of data (Richards, 2015). For example, the focus group study from case A, was named as UA-FG, and for interviews with nursing educators, were labelled UA-Int 01, UA-Int 02 etc. UB was used for case B and UC for case C. These case files allowed the researcher to categorise data sources for identified themes (King & Brooks, 2017).

The transcribed files and folders were saved under password protection to comply with the backup, confidentiality and privacy protocols of the home university (Richards, 2015).

After transcribing the data, the process of theme identification was started from each individual and focus group interview. Using NVIVO, it was easier to develop nodes and generate sub nodes to initiate the process of developing codes. Following the template analysis approach codes were categorised to represent similarity or specific relationships between themes (King, 2004; King & Brooks, 2017). For more clarity and thematic coherence, a detailed explanation on the entire process of data analysis and theme identification is presented below.

4.2.8 Managing data

It became evident that a suitable qualitative analysis programme would help in organising the themes emerging from the data. Hence, NVIVO software was used to help codify and organise the analysis (Richards, 2015; King & Brooks, 2017). NVIVO is useful in qualitative analysis as it has many technical features including voice and speed control tools which enable the researcher to read and re-read the transcript while listening to the audio files. Such digital tools enable the researcher to structure data and analyse the transcribed data under themes and sub-themes (Richards, 2015; King & Brooks, 2017).

NVIVO software is flexible and uses nodes (themes) and sub nodes (sub-themes) (King & Brooks, 2017). In each transcript and document set, relevant text was highlighted and categorised under appropriate sub nodes. The software allowed analysis of nodes within and across data sets and provided an indication of frequency, which was helpful in deciding which themes were pervasive (Richard, 2015). Memos were also developed while reading and rereading the interviews, to keep record of surfacing issues to be included in the discussion chapter (King & Brooks, 2017). However, when the data were printed, it was easier to code and identify sub-themes by doing some manual highlighting and going back and forth by keeping diary notes, using posted notes for each theme and for emerging findings (Richards, 2015). Manual analysis and notes were also found very convenient in revisiting the ideas and themes, when NVIVO could not be accessed due to technical barriers such as failure to connect with the internet or technical disruptions (King & Brooks, 2017). For manual analysis, data were categorised in separate cases with the specification of participants involved by using Microsoft Word (Richards, 2015). Each transcript and data set was identified based on the case reference and the participant groups involved (Yin, 2009; Kings & Brooks, 2017). Case study A was

coded as UA, case study B as UB, case study C as UC, case study D as UD and case study E as UE. For case study A, data gathered from the nursing students through focus group study was classified as UA-FG and for other cases, UB-FG and UC-FG, and so on. Interviews with nursing educators were marked in a similar way, for example UA-Int01, UB-Int01 and UC-Int01. This allowed easy identification of sources for quotes used to support the analysis (Yin, 2009; King & Brooks, 2017).

4.2.9 Data analysis

After establishing a chain of evidence from multiple sources triangulation was used to perform the pattern matching (Yin, 2009). Further description on the process of pattern matching is given in section 4.3.1 and 4.3.2. Pattern matching strengthened the scope of interpretation (Yin, 2009; Robson & McCartan, 2016). Combining findings from different sources (curriculum documents, semi-structured interviews and focus group studies) increased data reliability and validity as discussed in Chapter Three (Denzin, 1970; Kimchi et al., 1991; Robson & McCartan, 2016).

King & Brooks' (2017) template analysis is a flexible method for thematic analysis, useful in interpreting textual data. Transcribed verbatim data gathered from interviews and focus groups and data from documents can be coded using this approach. Codes can be developed and used to analyse similar and comparative themes or patterns to establish findings. A coding template was developed by the researcher using summary themes in a meaningful way. These themes were identified in relation to the research questions to explore the relevant subjective perspectives and experiences of the participants. Template Analysis, also allows the researcher to identify and use relevant direct quotes from the research data. Along with the interpretation of actual data, template analysis allows the researcher to infer meanings and findings in the context of the research question (Brooks & King 2012; 2014). The detailed process of template analysis is discussed below.

4.2.9.1 The process of template analysis

For this study, Template analysis has been used to organise and analyse qualitative data, thematically. Template analysis was chosen as it allows a flexible coding approach within a well delineated process (Brooks & King, 2012). The researcher may develop a variety of codes within the same theme (King & Brooks, 2017).

By performing thematic analysis of experiences shared by the participants, the researcher can develop a coding framework to structure the data interpretation in a systemic hierarchy (King &

Brooks, 2017). This approach is flexible as themes can be developed and divided as sub-themes based on the evolving understanding of the researcher, from initial to final template development. The coding frame or template is used to structure the analytic process (King, 2012). The process of developing a template by coding and developing themes is discussed below (4.1.5.5). In the light of King & Brooks (2017, p. 3), the following steps were taken to develop a structure for data analysis using template analysis approach.

A. Familiarization with the data

Beginning systematic analysis of a given data set requires familiarisation. Clearer understanding regarding the data develops through transcribing and reading the transcripts and listening to the audio records. In the initial stages of developing the template notes were made by hand and using the facilities of the word-processing programme (WORD) (Richards, 2015).

B. Preliminary Coding

Using King and Brooks (2017) recommended approach, the initial codes were developed. Coding is defined as, *the process undertaken by researchers through which they identify themes in accounts and attach labels (codes) to index them* (King and Brooks, 2017 p.28). These codes were the identified themes that appeared relevant to addressing the inquiry question. As discussed earlier (4.2.5), the data was transcribed using NVIVO software. The software enabled the initial coding through its specialised features through developing nodes (codes). In addition to NVIVO, to avoid any technical limitation, all interview transcripts were anonymously saved as Word document under the password protected files (King and Brooks, 2017). Word processor developed transcripts as double line spaced to enhance text clarity while reading. With a 4-5 centimetre, wide margins on right hand side, the researcher was able to write additional details next to the highlighted codes, on the transcript (King and Brooks, 2017). Structuring the transcript to initiate the coding process, facilitated the researcher to recognise potential themes and repetitive codes at different places in the transcripts. Appendix 9, illustrates different codes and categories that were created to display the data. At the stage of preliminary coding, some themes emerged as a priori themes, which were tentatively developed by the researcher to categorise data. A priori themes were identified from the context of the research question and literature survey (Brooks & King, 2014). A priori themes are preliminary themes that could be developed at an early stage that may or may not be relevant in developing the

final template as the researcher's interpretation of data evolves (King & Brooks, 2017). However, A priori themes were not found to be helpful as the analysis developed and were therefore discarded.

C. Clustering

As the themes were explored, they were meaningful categorised. A hierarchy of, sub-themes were formed and arranged under wider theme, based on same ideas, similar characteristics and any causal relationship (Yin, 2014). As suggested by King and Brooks (2017), emerging themes were written on sticky notes with particular colour codes to differentiate specific themes and sub-themes. Flow charts and some tables were formed to examine relevant information under specific themes and sub-themes. Appendix 9 illustrates how clustering was performed during data analysis. Clustering themes enabled the researcher to explore different ways to categorise sub-themes, creatively. Also, line numbers of each code and theme were mentioned on the sticky notes to refer back and identify any potential theme. Theme developed through digital and manual notes were compared several times (King & Brooks 2017).

D. Producing initial template

An Initial template based on emerging themes with any cross sectional - relation with other themes was developed. This process helped the researcher to develop more clarity in locating parallel and integrative themes. Parallel codes are those codes which could be classified within more than one theme across the lateral or different themes, whereas an integrative theme is one that is found across the other main themes. For example: an integrative theme, personal *vocation* was found a common sub-theme in all themes. A parallel code, *Fear* emerged in two different categories. 1. *Fear* of death while defining personal meaning of spirituality. 2. *Fear* of being judged or offending others while addressing spiritual care needs.

Appendix 11 illustrates the themes, sub-theme, parallel themes and integrative themes identified during the process of data analysis. Identifying parallel and integrative themes helped the researcher in developing open- mindedness and being non-prescriptive about structuring the initial template. The supervisory team was consulted for further validation of the codes and emerging themes at each stage of the data analysis (King & Brooks 2017). The detailed process of reflexivity during the data

analysis is discussed in Chapter Twelve (12.2.3). Several themes, sub-themes, parallel themes and integrative themes were identified for developing the initial template.

E. Developing the template

The initial template was applied to a larger sample of the data and modified over six iterations. Data from field notes, personal memos, audit trails based on the feedback from supervisors on each template and reflective entries were also incorporated to strengthen the relevance and rigour of the data analysis, essential for establishing quality assurance (King & Brooks, 2017). As I read and re-read the interview transcripts, every time a new interpretation and meaningful information emerged. To avoid confusion, due to overlapping ideas in each theme, I modified codes but kept the diary notes on each template. To bring more clarity, I constructed new themes and merged few sub-themes to establish potential connection. Through reflective dairies, I was able to do more revisions and could see emerging patterns in the data as evolving sub-themes. Hence, I re-defined themes creatively and deleted old themes. Revised themes and modified sub-themes were validated by the supervisors during monthly meetings and through regular email exchanges, every two weeks. As a result, reflexivity, which is highly required for performing an unbiased and in-depth data- analysis, was developed and enabled me, developing a final template for the study. A detailed account on the how diary notes were maintained at each stage of data analysis and how the audit trails from the supervisory teams' feedback were found very useful, is discussed in Chapter Twelve.

F. Applying the final template

The final template represented a hierarchical relation linking sub-themes with major themes, addressing the research question. Once the template was finalised and covered all relevant aspects without requiring any further changes; it was applied to all the data and used to analyse and interpret the findings. Through a process of rigorous analysis, the final template was developed to categorise data from each case.

Table 11 illustrates the final template used for data analysis.

Table 11: Final Template

Theme no.	Main theme	Sub-theme
1.	Conceptual complexity	<ul style="list-style-type: none">• Existential Aspects• Connectedness• Religious affiliation
2.	Choice-based	<ul style="list-style-type: none">• Personal Comfort and Creativity• Time and Environment• Non-Explicit in Nursing Curriculum
3.	Question of Authority	<ul style="list-style-type: none">• Fear• Role confusion: Nurses or Chaplain
4.	Spirituality can/cannot be taught	<ul style="list-style-type: none">• Vocational based• Quest for developing shared understanding• Framework for teaching and practice

G. Writing up

The decision was made to write up the data on a case by case basis and then to provide a synthesis of the three main cases. Chapter Five- Nine discuss the individual case studies and Chapter Ten presents the cross-case synthesis, noting similarities and differences between the cases that illuminated the research question and objectives (King & Brooks, 2017)-

4.3 Applying Template analysis in case study design

According to Yin, data analysis using case study design requires examination, categorization, tabulation and recombining evidence to explore robust findings and avoid any potential bias in drawing conclusions across the cases. To achieve reliable conclusions from each, case the following analytic steps, based on the strategy for multiple case study (Yin, 2014, p.45), were taken:

4.3.1 Step One- Constructing internal validity

Each case was analysed separately using the template analysis approach. Using template analysis for multiple case study design enabled the researcher to examine each case for empirical evidence as a response to the research inquiry (King & Brooks, 2017). In this study, each case showed their unique characteristics. By performing pattern matching, a chain of evidence was established which is essential to develop data triangulation. Triangulation is the process that enables; *convergence of data*

collected from different sources, to determine the consistency of a finding (Yin, 2014 p. 241). Data triangulation enabled synthesising data from all sources within the given case, and allowed the researcher to draw logical conclusions for the given case. These codes were further categorised as, themes and sub-themes and related on the basis of similar and contrasting ideas (Yin, 2009; Robson & McCartan, 2016).

According to Yin's analytic technique for case study design, this process enabled pattern matching to establish the internal validity of each case. The process of establishing internal validity is discussed in Chapter Three (3.3.5.1). Chapters Five to Nine present individual case studies comparing and analysing the data recorded from nursing educators, student nurses and curriculum review, categorised under themes and sub-themes. Data from all single case studies was also analysed for any rival explanations to strengthen internal validity checks. Rival explanations are alternative propositions different from study's originally set proposition (Yin, 2014). Rival explanations were used as an effective analytic strategy to perform pattern matching and find the congruency, similarity and differences reported from different data sources helping to establish internal validity of each case (Yin, 2014).

4.3.2 Step two - Constructing external validity

To assure the quality of data analysis, the importance of constructing external validity (Yin, 2009) is discussed in Chapter Three.

Once all the cases were reviewed, similar and contrasting finding were compared between the three complete case studies for literal or theoretical replications to establish external validity (Yin, 2009, 2014). Literal replication is defined as, "*the selection of two (or more) cases within a multiple case study because the cases are predicted to produce similar findings*" (Yin, 2014, p.239). Whereas, the theoretical replications are the, "*contrasting findings across the multiple cases*:" (Yin, 2014 p. 241). Chapter Ten demonstrates how external validity was established through cross-case synthesis. Data were compiled in a tabular form, summarising key findings from each case study. Those findings were then recombined as the similar and contrasting data to examine patterns across all cases. Cross-case synthesis allowed the researcher, having studied each case as a separate unit of analysis, then to aggregate and incorporate findings from all separate cases (Yin, 2009). Chapter Ten presents the main findings as a result of this cross-case synthesis. Cross-case synthesis is the evidence that

establishes external validity of case study findings by showing how similar and contrasting data were reported across each unit of analysis.

4.3.3 Step three: Contributing to knowledge construction

Yin (2014) suggested that based on data analysis and personal reflection, the case study approach allows the researcher ultimately to contribute to knowledge construction. Hence, findings gathered from the literature review and multiple case studies were combined to construct new knowledge (Richards, 2015). Consequently, based on the literature review and research findings a teaching framework SOPHIE was developed as part of the research output. Chapter Eleven, discusses the development of SOPHIE as one of the research outputs.

4.4 Chapter Summary

This chapter discussed the entire 'road map' that was used to conduct the study. There were challenges in accessing and recruiting participants for data collection but, considering the time-lines for this study, alternative options were explored to assure the validity and credibility of this research. Consequently, out of 13 universities, five universities were recruited for the study. Out of five cases, based on the availability of participants and curriculum documents, three cases had complete data sets. During the data collection phase, the availability of the recruited participants was an issue. However, this was also resolved creatively by providing some flexible options to the participants. Several measures assuring data protection and confidentiality were taken throughout the research process. Finally, this chapter explained how case study analysis techniques using template analysis were applied for robust data analysis.

Chapter Five – Case Study One: University A

5.1 Introduction

This chapter discusses the findings from University A (UA), the first case study conducted. A brief profile of UA is presented to provide an anonymous overview of this learning institution. Data collected from, interviews, the focus group and the curriculum review are classified under themes and sub-themes. These main themes concerned the following: conceptual complexities in understanding spirituality; that addressing spirituality appeared to be optional for students and educators alike; issues around authority (including fear of 'getting it wrong'); questions around whether or not spirituality could be taught and the quest for developing shared understanding. Finally, a data triangulation based on the findings from three different sources is presented; evidencing the internal validity of the findings from UA.

5.2 Profile

UA was established in 20th century. It is a large university in northern England with subject expertise in education, health and information technology. It sees itself as a leading university, developing its teaching and research rapidly in recent years. The university offers scholarship in biomedicine, engineering, physical sciences, social sciences, arts and humanities. It offers modular courses with strong vocational components. The university stands out for its academic standards and proactive approaches in addressing the diverse cultural needs of both national and international students. It has expanded facilities for enhanced IT and library services. The university has a comprehensive approach to recognising its staff and students for scholarly achievements.

5.3 Research findings

Six nursing educators and four student nurses from UA participated in the research study. The process of accessing and recruiting the educators and nursing students is discussed in Chapter Three. During data collection, it was found that UA had teaching faculty with special interest in spirituality in health and social care who had formed an interest group supported by the University and

attended by a variety of staff, doctoral students and representatives from NHS and Social Care organisations. The group aspires to develop a centre of excellence to promote research and academic rigour in approaching spirituality across various disciplines of health care.

As one educator stated:

We set up the group. I had support from colleagues who were interested. From school, senior management were aware what we were doing... Not with NMC, but we have been doing some work locally and with British Association for the Study of Spirituality. (UA- Int 03/L pages 705-706, 727)

Academically, nursing faculty members with a special interest in spirituality were approached by nursing and non-nursing staff members to offer sessions on spiritual care. With reference to the undergraduate nursing program, usually in year one and year three, an educator with a special interest offered formal lectures highlighting the need for and scope of spirituality in nursing care. The following themes and sub-themes were developed from UA using template analysis (King & Brooks, 2017). A detailed explanation on how the template was developed and the entire process of data analysis is given in Chapter Four.

5.3.1 Conceptual complexity:

Spirituality was defined and explained with multiple perspectives by all research participants. From a personal sense of connectivity to actualising one's potential, and from finding meaning in life to enabling others to find meaning in their lives; all were recognised as aspects of spirituality.

5.3.1.1 Existential aspects

An educator related spirituality to realising one's full potential:

Depends how you define spirituality. For me it isn't just about culture and religion and those kinds of things. It's about people reaching their full potential, in terms of their own spiritual wellbeing. And therefore, as Learning disability nurses, we teach people with learning disability to reach their full potential they aspire for. (UA-Int06/L207-210)

The same educator related spirituality to actualising potential and exercising autonomy including sexuality,

Spirituality is about reaching out to your full potential and being what you want, choices, and autonomy in terms of sexuality is linked with spirituality. (UA-Int 06/L265-266)

Both students and educators identified spirituality as a different concept to religion, spirituality not being confined to any structure or particular historical or traditional cultural setting. Also, spirituality was seen as a factor in resilience, defining personal coping and health-seeking behaviours in times of crisis and change.

One student in a focus group stated:

The way spirituality was brought in lecture, it was not just religion, it was at person level. We need to explore it on wider understanding with person's core belief, that's my understanding. (UA-FG/L18-20)

Another educator mentioned:

Certainly, I try to underpin, by saying valuing individual and acknowledge diverse needs, I would not necessary say spirituality. I would say about hope and strength focus, aspiration. Like in depression, we know people's goals and values are important for them...mood improvement that is something I do in teaching depression. It has spiritual aspect to that, engaging and connecting with people have spiritual dimensions. (UA-Int 05/L328-332)

5.3.1.2 Connectedness

One educator approached spirituality as a connection to one's own self and with others as:

Spirituality is a sense of our being and how we connect to the world. We do in learning disability nursing, as it is so much about helping people. To understand that personhood and to be a part of society and to speak to very individual needs, advocate for them, enabling people, to express themselves, I think it's integral to spirituality. (UA-Int 01/L898-901)

Another educator related spirituality to meaning and hope in life and proposed ideas of availability and vulnerability as a means of establishing connection in health care:

The fact that spirituality is a difficult concept for clinicians to understand so, my definition of spirituality is innately human. Giving hope, meaning and person-centred care...to mediate through availability and vulnerability, two ways of working to operate spirituality. (UA-Int 03/L803-806)

The concept of availability and vulnerability was further elaborated as:

Availability: Nurses understanding physical, emotional, professional availability. Vulnerability: Being willing to be human with your patient, willing to share your selves within boundaries, willing to be teachable and being actively engaging, to be self-reflecting and self-aware. (UA-Int 03/L 809-812)

5.3.1.3 Religious affiliation

Spirituality was found very much to be an embedded concept within religious beliefs. Hence, some nursing educators and students reported their uncertainties and underlying fear of offending others; if any misunderstanding or wrong messages were perceived by others while exploring spiritual care need.

As one educator mentioned:

Some people are intrinsically linked with religion so can't separate it with spirituality and that surprises me. They make their own definition in their own group, in relation to nursing. Most of them get similar things but someone will be there talking about in terms of religions and then I take it from there, otherwise they may feel offended. (UA-Int 02/L1308-1312)

A nursing student highlighted that:

Not deliberately I ask a person for spiritual care, but if person has depression and says that they have some religious affiliation, you might ask if they could be benefited from a religious pastoral care. Or offer them some literature to read. But its patient's choice. You don't suggest and don't impose on them. (UA-FG/L63-66)

5.3.2 Choice-based

Spirituality was considered as an implicit concept and it was largely a matter of choice for both nursing educators and students whether to embrace it as a legitimate care aspect during teaching and learning practices.

As one educator shared:

How well they connect and express, who they are. I think we are good at that. We are bringing it out to wider audience by talking about how do you work with some body in a very

person-centred way that enables them, to be that they believe they are, and to express that... but as I said, we do not explicitly use the term very often. (UA- Int 01/ L901-903)

Another educator stated:

I think we don't really do spirituality in [the] curriculum, it's done in the margins of curriculum. Whether that's good or bad I am not quite sure. Whether you are doing with death and dying, pain, traumatic role change...It depends how it is being taught and how it is being perceived. (UA- Int 04/ 443-448)

Spirituality was seen as a core in all nursing courses; embedded in the philosophy of care.

As one educator stated:

It depends on the field of nursing. Mental health and learning disability are far more open to certain degree to relate spirituality with the exception in adults in palliative care. I do teach in four fields, first and third year, its different field in each speciality. But I know spirituality is been talked about when they say palliative care, mental health nursing and learning disability. When we talk social and holistic care and person as whole, we talk about it. But when we talk about specific illness, it is lost and not covered. (UA-Int 02/L 1142-1147)

Students during the focus group acknowledged that specific faculty members, based on their own personal interests, did recognise and generate discussion about spirituality, but it was not considered as an explicit theme, *labelled* as spirituality during all teaching and learning practices. As one student highlighted:

Some tutors are different in a way they would approach it (spirituality). So, you can tell with the lecturer I work, you can feel that openness or if it is not so...Some will not even refer to it (spirituality) at all. We are doing leadership now, but there is not spirituality, you have to mention it. So, if something you are not teaching or teaching how to approach it, student is not likely to apply it. (UA-FG/L145-149)

5.3.2.1 Personal Comfort and Creativity

Spirituality was introduced as core part of nursing philosophy and related to caring presence and self-reflection by some educators. Often, pastoral care, religious beliefs and values were discussed to identify spiritual care need. As one educator shared:

You need to be creative to relate spirituality while talking about people's reaction to loss and change. Spirituality is part of that. It will be in module specification in some subjects, like nursing concepts and care approaches. (UA-Int 06/L245-247)

One educator, related spirituality in reference to learning difficulty and sexual health as:

That's why I pull out all these things. This is blocking my client group's spirituality, because they are not allowed to do lots of things in terms of their sexuality. (UA-Int 06/L270-272)

Another educator shared:

Looking at holism we start with a very basic key concept...you know. Sociology for example, sociological influences, psychological influences, biological influences. Then we become pragmatic and give scenario. And, if you are from different background, how would you fulfil your role that affect your care approach. (UA-Int 02/L1199-1203)

Some educators saw therapeutic communication and reflective skills, as teaching strategies to address spiritual care needs:

With reference to learning disability, they don't have the opportunity to be autonomous so that is spiritual...what we aim to do now is teaching student how to work with somebody. One of the techniques is called intensive interaction and it involves being with somebody and really being with somebody and communicating with them at a very deep level. And often we use mirroring, so whatever the person is doing the practitioner would join with them in that activity...and people spend time to bring everybody into a very shared space. (UA-Int 01/L999-1006)

Other educators focused on holistic care, compassion, and being fully present as ways of mediating spirituality:

Some educators throughout pre- or post-registration, would consistently highlight holistic care issues, may not use spirituality but they may talk about compassion, listening to patient, and caring presence in all core nursing skills, which you can argue are fundamentally spiritual and holistic. (UA-Int 03/L 721-724)

Another educator while sharing her teaching experience of engaging students in reflective practices mentioned how reflective activities could be useful as transformational learning approaches. She

asserted that through reflective practices students could be facilitated to find ways where they can support their patients to become more empowered and free. She mentioned:

Absolutely in reflective practices... it is amazingly transformational. The spirituality sometimes comes in there because we are talking about it (spirituality), again not overtly but what it means for their patients to be able to make decisions and choices by discussing scenarios of dementia, diabetes..., I get them talk about how much control and autonomy their patient has on their life. Their patient's sense of self, dignity always comes out. It's about their professional role. Helping patient to be as person, the patient wants to be. As fully human beings they can be. (UA- Int 04/L431-439)

For some students, spirituality was viewed as, "something extra", along with the essential nursing courses to learn and be assessed for:

There is something extra to learn. My friend is here to be nurse to treat patients, you try to teach them to treat but from even at [previous] college in health and social care, you [health education system] don't teach spirituality. (UA- FG /L110-112)

5.3.2.2 Time and Environment

The nursing curriculum tends to emphasise narrowly defined evidence based practices focusing on disease-centred approaches. Hence holistic care components may be squeezed out. Generally, the acute care aspects get priority over anything else in nursing education, leaving little scope for spirituality to be integrated.

An educator said:

...because care is so acute that there isn't a lot of space for doing spiritual care. (UA-Int 04/L843-844)

... not even just disease actually, its function centred. Get the job done, what is needed to do to keep the person safe. So, that is about time and emotional space. I never saw staff coming more than once to get to know. It's really sense of dislocation thinking. (UA-Int 04/L504-507)

I think the standard for pre-registration is tighter and tighter, and things get lost. So, it makes it [integrating spirituality in teaching] more difficult. (UA-Int 03/L844-845)

Students recognised the difficulties of environmental pressure, time constraints and task expectations during clinical and community placements affecting their care delivery:

In community, assessment is rather more detailed. But in [acute] clinical we just have to do tick and sign our names. Nobody teaches you how to fill out forms and no details, it's just task based. (UA-FG/L194-195)

Time constraints and environmental pressure in relation to particular speciality areas were mentioned by one of the educators:

One of the things, I know we benefit in learning disability services is that we do have luxury of time. You might not get it for example in A&E, where you may have somebody coming in for hours. And so, only the skilled practitioners can make those connections with people very quickly. (UA-Int 01/L1026-1029)

Educators also expressed reservations:

...and if you ask undergrad student they will write a whole essay on holistic care, how they looked after the whole patient, but the reality is that the system does not encourage that, and just not make space for that. (UA- Int 04/499-501)

Initiatives to meet spiritual need (outside of normal nursing practice) were, however, recognised:

Certainly, curriculum is about evidence-based practice. There is a tension between evidence-based practice and individuals. For example, the Creative Mind organization tries to empower people, by doing things artistically that may involve spiritual dimensions to it by engaging heart and soul- (UA-Int 05/L356-358)

Patients' health-seeking needs are assessed based on clinical evidence only; hence a limited or a narrow scope for spiritual care integration remains in clinical practice. Students during the focus group study recognised this as a difficulty associated with polarised disease-centred nursing diagnosis:

There is different paper work but we don't develop nursing diagnosis, nurses don't make diagnosis. We do OSCE, how would you treat a patient. ABCD options are selected but we don't make diagnosis. We are taught to identify symptoms. (UA-FG/L185-187)

Another student added:

We go through the tick list, nursing assessment tool and tick it off, as it is expected. (UA-FG/L188)

5.3.2.3 Non-Explicit in Nursing curriculum

Spiritual care was often perceived as an aspect of the person-centred care or holistic care. While identifying ways of addressing the spiritual care needs, participants shared this concern as a generalised impression associated with the term spirituality. One educator was uncertain about how or even whether spiritual care competencies were assessed:

I am thinking whether we do assess them or not, but not sure in terms of spirituality is down there as a name, is assessed. But we see students performing assessment on person-centred assessment, so you can't ignore it. (UA-Int 06/L297-299)

This reflected another educator's view that spirituality was often subsumed under different categories:

It [Spirituality] is not explicit. There are aspects of this [Spirituality]. Example, like value-based nursing, importance of that, self-awareness, reflection, importance of recognising diverse background, respecting, it's all about and being person-centred is all about spirituality. (UA-Int 05/L311-314)

Again, another educator felt that spirituality related to compassion:

There is more in terms of compassion, as it is one of the 6Cs and been taught and that element is assessed by essay, by understanding and application of 6Cs. Clinical portfolio and ticking, working with mentor, it has the element of it. These are individual strategies but no way of formalising the course and evaluating when they left. (UA-Int 02/L1325-1331)

They cover when they say holism. Spirituality is an aspect of holism, but it is not given same emphasis. Emphasis is tending to be on psychosocial, biological elements and spirituality sometimes lumped in psychological aspects. (UA- Int 02/L1155-1157)

One educator mentioned:

I am thinking of any skill and competence we lay out. Talking in depths that we understand spiritual need. I am not sure that it is explicitly there in a large way. May be in a small way. I mean, NMC talks about the need to respect and work with diversity and talks about Person-centred way, we are at the beginning of the journey with that in terms of who are you and what can I do to support in ways you want to be supported, I think there is work to be done. (UA-Int 01/L 938-943)

5.3.3 Questions of Authority

Several challenges were identified by the participants while discussing the factors influencing the integration of spirituality in nursing education. These challenges were rooted in political ambiguity and a lack of clarity about how to approach spirituality in health care. These challenges included fear of being misunderstood by patients and families, lack of role clarity, confusions related to personal values and beliefs in a multicultural society, time and environmental constraints and dilemmas related to acute care priorities.

5.3.3.1 Fear

For some participants, it was personal values and religious beliefs that strengthened their determination to empathise with others. However, for others, personal beliefs were the source of fear and anxiety. The fear of being misunderstood and offending others was a challenge for both students and nursing educators.

One nursing educator shared:

I have learnt the hard way. Everybody's opinion is valued. Experiences are shared. Because, sometimes people strongly disagree to the point that they walk out. Particularly when they have religious structure and they may not agree, and refuse to talk about. So, I am very careful not to cause any offence. (UA-Int 02/L1300-1304)

Another nursing educator related fear to the complexities of working in a multicultural society:

I think people think it is nothing to do with me, it's not for me and therefore I am unable to support somebody else, to participate in some sort of worship or discussion or may be and lot of different religions in UK. And I wonder people worry of getting it wrong and people's fright of supporting any culture in an inappropriate way because perhaps they don't understand enough about it. (UA-Int 01/ L929-933)

The underlying fear of inadequacy and lack of preparedness often results in avoidance, as one educator discussed:

Generally, it [teaching spirituality] seems to be bit of avoidance about teaching spirituality per se. Some of them may have feelings that people are quite offended...A colleague of mine needs a module on spirituality and before I said anything, they said I will do anything, will do all marking, and they did it for me and I said why you don't want to do it. They said, it's not me, it's not me. So, this [teaching spirituality] is being avoided. (UA-Int 02/L1126-1132).

It is interesting that some of our colleagues say, oh that is spirituality...so there is a problem with Nursing educators in general, not understanding what it is... when we did the research it clearly showed that though spirituality was found to be important to educators but they were not sure how to apply it. (UA- Int 03/L693-696)

One student asserted:

Some students they don't want holistic...holistic care is not for every practitioner. (UA-FG/103)

Some participants identified their fears and anxieties due to lack of confidence and competency to address spiritual care need.

5.3.3.2 Role confusion - Nurses or Chaplains

One student asserted that:

Spirituality as essence of yourself, I said, spirituality and sexuality, but then some cultures and religions still don't believe it is right, but as a country we are very open now to what we expect now. (UA-FG/127-129)

... the whole terminology requires defining, as this is tricking us. What is spirituality?... that causes problems. (UA-Int 06/293-294)

A nursing educator identified the role confusion and embedded anxiety as:

The formal assessments, when you assess somebody's mental wellbeing, nothing specific is asked. They will say what's your personal spiritual needs, but generally it is with reference to religious needs, pastoral needs, or prayer. It is limited if somebody wants to go beyond that. (UA-Int 02/L1181-1184)

5.3.4 Spirituality can/cannot be taught

Not all educators and students agreed that spirituality can be taught in the same way as other nursing subjects. Some participants related spirituality to personal vocation in choosing to be in a caring profession. However, all participants emphasised the need to integrate spirituality in nursing education and to develop a shared understanding among professionals.

5.3.4.1 Vocational based:

Several interesting views were shared by the participants when asked whether spiritual care was vocational based or could be taught as a formal course.

An educator raised her concern by saying:

No, you can't teach to be compassionate, you feel compassion. (UA- Int 02/L1237)

Whereas another educator shared:

I think it [spirituality] can be taught, we can enable people to think about their own perspective and what life means to them and where they see themselves fitting in this world. (UA-Int 01/L1074-1075)

One student nurse during a focus group mentioned:

It [spirituality] is just sort of a known factor that you know people to be treated differently. (UA-FG/73-74)

Another view from a student was:

We had a session in year 1. big lecture on spirituality. It was on how it effects on care we give and in other individual seminars... it was not that in depth but just the basic. You can't learn it [spirituality] in nursing until you practice it. (UA-FG/L03-05)

An educator shared the view:

I feel sad that we have to get to telling nurses what they should be doing. It [Spirituality] fits with their vocation, their desire to care for others and support people in distress... We should be teaching them in terms of constant cycle of holistic practice which involves caring for a person holistically. And that includes biopsychosocial and spiritual. But it is sad reflection on society that we need to teach people to listen to patients and to sit down and hear their stories and to explore their distress and give some comfort, that makes me sad but I think we will continue to do that. (UA-Int 03/L786-787, L793-798)

Spirituality was regarded as an intrinsic personal characteristic or behaviour that cannot be taught; but developed and nourished through personal experiences.

One student shared:

Personally, I am religious but I channelize them [patients] if they want to go for religious prayers, my tutor never discussed such issues. (UA- FG/ L80-81)

Another student highlighted:

I have been taught to look at the client as whole but never be told how to treat them as whole. It [Spirituality] could be about religious beliefs but not otherwise, so we don't give them that appreciation. We were never taught! (UA- FG/ L132-134)

Whereas one student said:

Even for an hour session, students say why do we want to spend an hour, they would say it is pointless lecture. People don't understand the importance of spirituality and how it effects on patient's care. There is no way to drill them [spiritual care approaches] in someone's mind, they will treat their patient, the way they want to treat their patient. (UA-FG/L92-95)

Case One offered formal teaching for an hour in year one and year three of the undergraduate nursing programme. However, from the educators' point of view, it was a matter of students' personal interest and choice as to how they related this to their learning and clinical practice. For example:

We talked about scenarios. Some students relate it, some just dismiss it... just tick the box and never give it a thought. But some students come and discuss the situation and relate how they change their questioning technique or what they have viewed differently. (UA- Int 02/L1315-1318)

5.3.4.2 Quest for developing shared understanding:

Both nursing educators and students suggested some way forward to embrace spirituality with more confidence and competency. Students during the focus group recognised the need for more sessions on self-awareness to understand their own spiritual needs, before extending support to others:

It is very important to explore student's own spirituality, as sometimes it is only for patients but not for students as such. So, if you don't know it by yourself, how to expect it for others. You find yourself and transform yourself ... by having more empowerment, what I want to do now. (UA-FG/L166-169)

An educator emphasised that:

We need to teach students about, self-preservation, developing adaptability. This will enable students to cope with burnout and sensitivity towards their own need. It is related to developing resilience in students to face trauma, stress related to meeting targets, working with people and developing compassion fatigue. Nobody prepares anybody for burnout. (UA- Int02/L1265-1270)

Another educator suggested more discussion sessions around psycho-social aspects:

I would like to see more discussion around it. Might sit with discussion with psychology and sociology because they start touching on what peoples' experiences are, both individual and

at group level. So how we experience ourselves, as community etc... that may be natural extension, we may begin to talk more deeply about. (UA- Int 01/L1035-1038)

A remarkable step was taken by faculty members in UA to orient multidisciplinary teaching staff with the notion and scope of spirituality in health education. As one nursing educator mentioned:

There has been a shift. Initially there was lot of resistance from colleagues. People who perceived religion and spirituality is the same, so I should not bring this to university. And I got email how dare you do this, and other people saying, indicating same..., very difficult time initially. But I managed it quite gently and ran spirituality and health care study days and invited people. I did that for 3 years and had 300/400 people got through, and had module on it for a year. Then spirituality interest group was developed and now people know that they can invite us to teach. (UA-Int 03/L685-691)

Such a forum where multidisciplinary staff in general and nursing educators in particular were provided help and support to discuss their fears and anxieties was unique in the cases studied. Some participants suggested that spirituality should be discussed and integrated in all nursing courses. One student said:

It [spirituality] should be taught in all courses and lectures rather one separate lecture on spirituality. (UA-FG/L150-151)

An educator reported:

Year 1, and then in Year 3... for two hours, specific sessions on spirituality. But it must be covered in different ways in other sessions. (UA-Int 02/L1321-1322)

Another educator mentioned:

No, I am not satisfied [with existing nursing curriculum] but it is a start, but am enthusiastic too. The text is contradictory and it is impossible to have a definitive definition of spirituality. It is important to have more UK research. I looked at as specialised practice - it is all American. We have good nursing theorists, but we need more robust empirical research. (UA-Int 03/L742-747)

5.3.4.3 Framework for teaching and practice

Nursing educators at UA mentioned that there has been a difficulty associated with the term and concept of spirituality for some of their colleagues. Hence, they emphasised developing a shared

understanding through more discussions and mentorship for educators. This may facilitate educators to relate spirituality in nursing education.

One nursing educator suggested introducing mindfulness training and value-based supervision for educators as well, so that educators can develop more confidence in relating to spiritual care needs both for patients and their students.

We may introduce mindfulness training, so engage in now and then... and person in-front of them. There should be value based clinical supervision for both educators and students. (UA-Int 05/L368, 374)

Another educator mentioned:

Some of the things, I think should be there in curriculum. These [spiritual care aspects] are difficult to quantify in curriculum. Care, passion, compassion which one of that is spirituality? Because they are doing really one definition of spirituality and for 100 different people; you may get variations in them. So initially whether we call it spirituality or not, it does not matter. We talk about feeling and compassion it has to be there in curriculum. And how to teach some body to be compassionate, and to teach some body, how you get about that but teaching what it means to be compassionate, that certainly needs to be there in curriculum. (UA- Int 02/L1227-1234)

This concern was shared by a further educator:

... in one sense, it [the extent of integration] is a shame and we could do more. Because within the culture of our health systems and education system it [spirituality] is not something talked about, it is very much seen as private issue. (UA-Int 04/L464-468)

Students emphasised that spiritual care aspects should be part of clinical teaching and it must be integrated with nursing care plans. As one student said:

It (Spiritual care aspects) should be part of care plan in hospital environment, to bring hope. (UA-FG/L175)

5.3.5 Curriculum review

Three Course grids for BSc Yr. 3 nursing courses were reviewed along with the undergraduate hand book for exploring the assessment criteria set by UA, to assess students' competency and skills development to address spiritual care need.

5.3.5.1 Findings

UA was using modules for teaching each course in undergraduate nursing education. For each course module, spirituality was identified implicitly and explicitly in curriculum documents threaded with different nursing components under person-centred, holistic care, spirituality and wellbeing and in reflective practices. However, no knowledge or skill based assessment criteria were found to assess the competency required to understanding and addressing spiritual care needs in undergraduate nursing curriculum. A module specification where spirituality is discussed both explicitly and implicitly (as mentioned by the nursing educators and students); is illustrated in table 11 below.

Table 11: Curriculum Review- UA

Name of Module	Themes in Module where spirituality is explicitly or implicitly integrated
Nursing Concepts and Care Approaches	<ol style="list-style-type: none">1. Spirituality2. Sexuality3. Compassionate care
Foundations of Nursing 1	<ol style="list-style-type: none">1. Spiritual beliefs2. End of life care3. Religion4. Dignity and privacy
Foundations of Nursing 2	<ol style="list-style-type: none">1. Person and family centred care

5.4 Data Triangulation for UA

The process of data triangulation is considered very important to establish the internal validity of a single case study (Yin 2009; Robson & McCartan, 2016). This section summarises the relationship between data from the three different sources (documents, interviews and the focus group) to illustrate the degree of agreement between them. Chapter Three and Four discuss the need and process of constructing internal validity in a case study.

Data collected from nursing educators, student nurses and curriculum review at UA revealed that both nursing educators and students acknowledged the breadth and complexity associated with the term spirituality, particularly in a multicultural environment. Spirituality was understood as connection, hope, meaning, actualising potential, compassionate care and as a phenomenon with a variable relationship to religion. Two participants related sexual expression with spirituality as well, which illustrates the breadth of the wider meaning of spirituality to different people.

However, for all students and some educators, spirituality teaching and learning was a challenge due to diverse religious and cultural environment. Particularly for students, a fear of being misunderstood and offending others and a lack guidance from educators led to some avoidance of discussing spirituality in classroom or during clinical experience. However, based on educators' personal interest and level of confidence spirituality was integrated in undergraduate nursing education across different modules to some extent as verbalised by educators during the interviews.

Such variation in teaching was obvious through curriculum review, due to the modular structure of the curriculum; there was no detailed description for any specified theme. It was exclusively a matter of choice for nursing educators to decide what to teach and how to teach under each module specification. This was also validated by the educators' responses. All six educators emphasised the importance of spirituality in nursing education. However personal choice and workload affected the extent to which this was realised. Aspects of spiritual care were addressed explicitly or implicitly, to different extents and from different perspectives, based on the personal choices of educators at UA.

Although, UA has some specialised educators who take formal class room teaching sessions in years one and three, no student assessment or evaluation of those teaching session was routinely undertaken. There was no evidence of assessment of students' competencies or learning needs in understanding spirituality in nursing practice. Students affirmed that, based on educators' personality and subject expertise, spirituality was taught as a formal class room lecture, but rarely mentioned during mentorship and small group tutorials. Student identified that because of time pressure and clinical priorities, spirituality in practice was generally perceived as the same as ticking a box to identify the patient's religious affiliation. Students reported that spiritual care was not a priority concern in classroom teaching or clinical practice.

To students, spirituality was in the same area as person-centred and holistic care, which are important underpinning concepts in nursing philosophy. On the whole students did not feel adequately prepared through nursing education to address these issues. All participants reported that because of a lack of clarity in the nursing curriculum spirituality was often overlooked and not specifically explored under the generic term of providing person-centred, holistic care. An explicit explanation of the term spirituality, role clarity in addressing spiritual care needs and adequate professional support was felt to be essential to integrate spirituality in nursing education. These findings were matched with the propositions (Chapter Three, 3.3.2), initially set for the case-study for any rival explanations (Yin, 2014). However, no rival explanation was identified contrasting with initial propositions. This confirms the internal validity of the case findings from UA.

Chapter Six. – Case Study Two: University B

6.1 Introduction

This chapter discusses the findings from University B (UB), the second case study conducted. A brief profile of UB is presented to provide an anonymous overview of this learning institution. Data collected from, interviews, the focus group and the curriculum review are classified under themes and sub-themes. These main themes concerned the following: conceptual complexities in understanding spirituality; that addressing spirituality appeared to be optional for students and educators alike; issues around authority (including fear of ‘getting it wrong’); questions around whether or not spirituality could be taught and the quest for developing shared understanding. Finally, data triangulation based on the finding from the three different sources is presented, evidencing the internal validity of the findings from UB.

6.2 Profile

UB was founded in the 20th century. The vision of UB is to promote access to quality education in the spirit of social justice and equality and to actualise individual potentials, which could otherwise be marginalised. Courses are offered both face-to-face and online. UB prides itself on offering alternative learning pathways to students and improved curriculum structure by offering flexible learning opportunities.

6.3 Research Findings

Two nursing educators and seven student nurses of UB participated in the research study. The process of accessing and recruiting the educators and nursing students is discussed in Chapter Three.

The university believes in value based recruitment of nursing educators to offer pastoral support to their nursing students. It was reported by the participants that spirituality was generally considered to be an embedded concept in holistic and person-centred care.

The following themes and sub-themes were also found in UB using template analysis (King & Brooks 2017). A detailed explanation of how the template was developed and the entire process of data analysis conducted is given in Chapter Four.

Themes which emerged after detailed data analysis are discussed below.

6.3.1 Conceptual Complexity

Participants shared a variety of ideas when asked their views on spirituality. Some saw attention to spirituality as part of holistic care while others related it to traditional concepts of religion. For a few participants, spirituality was a connecting force to find meaning in relating with their loved ones.

6.3.1.1 Existential aspect

A broad term of holistic care was used by the participants to include what spirituality meant to them. Spirituality was not so much seen as an explicit dimension of holistic care but as being implicit in the concept.

One educator shared:

I think my impression on spirituality would be really looking at holistic person. (UB-Int 01/L536)

6.3.1.2 Connectedness

With reference to spiritual care needs, participants elaborated that therapeutic communication and enabling patients to “connect” was about spiritual care.

For students, spirituality was characterised as follows:

It about connectedness. Connecting with someone. It could be meditation, beliefs, systems, personal, different things to different people. (UB-FG/L1365-1366)

Another student mentioned:

Personal feeling of connectedness. (UB-FG/L1369)

One student sharing a personal experience during clinical attachment said:

It could be very emotive, they would have lot to tell, and life experiences... all he (a patient) wanted to do was wanting to see his dog. So, we arranged to bring dog in ward. For me it was

kind of connectedness... Before he was isolated. After that he just almost like alive again.

(UB-FG/1374-1377)

Another student asserted that:

To me it's more listening and giving more time. Getting to know someone. (UB-FG/L1383)

Spirituality was related to caring presence. A nursing educator related the concept of spiritual care as:

To me it is about being there with patients, understanding them and providing holistic care.

(UB-Int 02/L520)

6.3.1.3 Religious Affiliation

During the focus group, a variety of responses were gathered when students were asked about spirituality.

One student saw spirituality as going beyond religious ideology and shared his feeling of apprehension, when encountering a person with religious belief:

As somebody has belief in religion... I feel apprehensive. (UB-FG/L1369-1370)

However, to another student spirituality and religion were inseparable concepts:

To me religion and spirituality is intertwined together. (UB-FG/L1409)

Another student expressed that the relationship between religion and spirituality had changed over time:

What was the meaning of religion as in olden days we used to think, it's much more than that.

You don't have to be religious to be spiritual. (UB-FG/L1464-1465)

6.3.2 Choice-based

Nursing educators related the concept of spiritual care to person-centred care, as well as to student-centred learning. Providing an enabling learning environment, on-going feedback and offering students timely support was considered to be addressing the spiritual care needs of the students.

6.3.2.1 Personal comfort and creativity

Several approaches relating to spiritual care were identified by both educators and students. Those approaches were based on educators' personal choices, comfort level and creativity. An educator mentioned:

I employ specific practice tutors for quite a pastoral support role as well as the practice requirement. But their role is to really [to] remove the barriers for the students. Really get to know those individuals very well and to create a kind of a culture of support with no barriers. So how I see spirituality is about looking at a real individual what are their needs. And that is how I train my practice tutors to be. (UB-Int 01/537-541)

Students supplemented the educator's views:

My mentor sits set back and allows me to think, to prepare for difficult conversations, on learning curves, to make me more confident. (UB-FG/L1425-1426)

Another student whilst talking about end of life planning said that:

We do discuss what [the] patient is feeling. Spirituality is to do with the state of mind and feelings. Our patient expressed his fear, we discussed that. Even at hand over. (UB-FG/L1429-1431)

The nursing educators interviewed did not know whether aspects of spiritual care were explicitly addressed and discussed by other educators or clinical tutors, as they were both programme lead facilitators and were not involved directly in face-to-face teaching. However, they assumed that, considering NMC expectations, students were adequately prepared to deliver holistic, person-centred and compassionate care but uncertain as to how spirituality was covered within this:

I don't know. To be honest and its really bad of me. I don't know, exactly how spirituality is actually covered within module, or how they (Educators) focus on it. I know they will be focusing on patient as whole and holistic care. But, I don't know how specifically they deliver it. Or when tutors mark assignments, what they might be looking at in relation to that. I don't know, how its covered in modules. (UB-Int 01/568-572)

6.3.2.2. Time and Environment

Students shared time and workload pressures as a primary challenge in approaching spiritual care needs of their patients:

Every nurse you talk to, they are bombarded with paper work. One emergency takes you away from other patients. One day I walked in room. She lost her brother. She took his photo and started talking and talking, but there was emergency and I left the patient. I ignored it, like I shut her down. (UB-FG/L1437-1439)

Another student related the work pressure to the nature of clinical placement. He asserted that their care priorities changed on the basis of the clinical environment:

Depends on environment. If you work in community, it's different. If you are working in acute care trust it's different. (UB-FG/L1444)

It's about time. You have patients to see, so much paper work. Every patient wants to say. You need to give time and talk more. When you sat with them and actually listening and allow them to talk and not pushing, because its personal. (UB-FG/L1391-1393)

6.3.2.3 Non-Explicit in Nursing Curriculum

Spirituality was addressed as a core component of holistic care. It was defined as an implicit dimension of care embedded in the nursing philosophy. However, spirituality as an explicit expression appeared to be overlooked in nursing education, due to other academic priorities. As one educator shared:

..... as a direct module, I am certainly not aware of it. Certainly, not in nursing. There would be completely integrated in programme. I have no doubt, because patient as a whole has to be looked at for everything in observation with NMC. There is so much you have to fit in to the curricula. (UB- Int 02/502-505)

6.3.3 Question of Authority:

The programme lead facilitators for the undergraduate nursing programme at UB were not involved in direct teaching and were unaware of any technical challenges their other educators might encounter while focusing upon aspects of holistic care. Nursing educators believed that their educators and

practice tutors were competent in fulfilling NMC requirements and preparing students to deliver holistic care. The challenges around authority in this case were voiced by students only.

6.3.3.1 Fear

Students mentioned the fear of being misunderstood owing to religious differences. Sometimes, the fear of projecting personal ideas related to death and dying onto patients became a challenge for students, as end of life and rituals around dying were often perceived as areas where spiritual care was relevant. One student shared:

Saying wrong things to them, worried about saying wrong things. What you mean by? umm, you make suggestions what they want to hear. If they are seriously ill, and you ask them to see religious person, they may think, oh I am dying therefore you are asking me. Even if I am not thinking about dying but it's nurse giving impression. (UB-FG/L1403-1406)

Students discussed how they encountered fears and anxieties in clinical settings and felt inadequately prepared to address the spiritual care needs of their patients:

I was on older acute ward and before I went to placement, I feared how would I get connected with them. (UB-FG/L1372-1374)

6.3.3.2 Role confusion - Nurses or Chaplain

During focus group study one student related spirituality to chaplaincy care and mentioned that there were no formal courses or clinical requirements to develop competency in nurses to provide spiritual care as chaplains.

Spirituality is way down in the hierarchy, definitely. No specific or not a deliberate attempt as an explicit element in nursing courses that requires specific exposure in chaplaincy care, specific days' placements or training. (UB-FG/L1456-58)

6.3.4 Spirituality can/cannot be taught

Students presented a variety of views on whether spirituality could be taught as a formal course.

Some students emphasised personal experiences and personality factors in embracing spiritual care,

while others identified the need for getting more confidence through formal teaching sessions. One student asserted that:

We need more education on [this] topic. If you start firing questions, it will shut them [patients] down. (UB-FG/L1386)

6.3.4.1 Vocation-based

Students shared that it was all about personal set of values and life experiences that shape your personality and professional accountability.

You need to have skill of adaptability. It's the personality of the nurse. The book can tell you much about theory, but experiences make you learn. (UB-FG/1419)

Another student identified the potential dilemma in teaching spirituality as a formal course. Since spirituality was related to personal experiences, it was difficult for it to be taught. However, students wanted some knowledge and competency to understand how to approach spiritual care. They felt that educators should provide adequate support and clear guidance to develop confidence in students.

They (nursing educators) should teach us how to ask questions and how to be aware of spiritual care need. Because you can't teach what is it. Because it's different for everyone.
(UB-FG/L1468-69)

6.3.4.2 Quest for developing Shared Understanding

Both nursing educators and students came up with some suggestions to develop more helpful learning structures, preparing students to understand and address spiritual care need.

An educator suggested that:

There is an element I would take out from curriculum, to make room perhaps [for] more person-centred journeys. I would like to see more person-centred journeys, but I know the reality is we have got lot of student nurses, now from all backgrounds, I think each field in nursing is now becoming more generic and that I don't think is helping..., it's far too generic.
(UB-Int 01/633-641)

A student nurse suggested an online learning resource could be introduced as a flexible option for students to learn about spirituality.

We need spirituality to be integrated in teaching and training...could be introduced in e learning. (UB-FG/L1399)

6.3.4.3 Framework for teaching and practice

With reference to some students highlighted that clinical placements were often stressful and, due to work load pressures, person-centred care was often compromised. Hence, a more structured approach was suggested to develop understanding of spiritual care in nursing education:

There should be more detailed ward rounds. I believe in-depth discharge plans, privacy time to discuss more in private rooms, adequate time, I mean protected time, should be there.

(UB-FG/1435-1436)

6.3.5 Curriculum Review:

For UB, only the undergraduate Programme guide was found as a reference document for undergraduate nursing courses.

6.3.5.1 Findings:

The programme guide had module titles with brief over view only. The *NMC progression requirements*, for each unit were mentioned. In contrast to UB, in UA a syllabus outline was found. Also, in UC, details of each module and sub-themes aiming at specific competency domains were also found threading across different units and modules. A module specification where spirituality was found integrated implicitly (as mentioned by the nursing educators and students) in nursing curriculum is illustrated in table 12.

Table 12: Curriculum Review- UB

Name of the Module	Themes in Module where spirituality is explicitly or implicitly integrated
1. The science of the mind: investigating mental health 2. Principles and skills for nursing practice 3. Exploring perspectives on health and illness	1. Bio-psycho-social model 2. End of life care 3. Compassionate Care

6.4 Data Triangulation for UB

The process of data triangulation is considered very important to establish the internal validity of a single case study (Yin 2009; Robson & McCartan, 2016). Chapter Three and Four discuss the need and process for constructing internal validity in a case study.

From the educators' perspectives, spirituality was considered to be implicitly covered in holistic care teaching. Due to the flexible learning structure offered by UB, only programme lead facilitators for the undergraduate nursing course could be accessed for the study. Both educators were involved in planning various classroom teaching and clinical placements across the programme. However, they could not report any direct experience of whether and how spirituality was integrated in undergraduate education at UB. Nor could they identify any challenges or factors that could have affected the extent and level of integration of spirituality in nursing education. They focused on meeting the NMC progression requirements and expressed confidence in their colleagues that if the NMC had recognised spirituality as an essential component in nursing education, then it must have been covered during class room teaching and clinical placements. However, UB did not have any monitoring or evaluation structures to inform whether and how spirituality was addressed in nursing education.

On curriculum review, only a brief course guide introducing different units and credit points was found as a resource for students and educators.

Educators identified that students are offered 1:1 support for their personal growth and professional growth. This seemed to be where aspects of spirituality might be addressed in nursing education at UB. Students reported that they did receive adequate support and mentorship for their personal and professional development. Spirituality was seen as a complex issue that was intertwined with religion, but could also be seen as a meaning giving aspect of human life independent of religion. It was also seen to be about feeling connected with others and related to end of life care. Hence, students wanted more guidance and clarity on their nursing role as distinct from chaplaincy care. Students asserted that, owing to the priority given to a disease-centred approach, social and spiritual care aspects were overlooked in both teaching and clinical care settings due to time constraints and clinical work load. Students wished to have more clarity and discussion about spirituality in nursing education, believing it could help to develop more personal competency and promote quality care.

Data triangulation based on curriculum review, educators' views and students' perspectives demonstrated that although spirituality was considered as an important aspect of holistic care, explicit articulation of this in the curriculum and teaching and mentoring was not found at UB. Data findings from UB were matched with the propositions (Chapter Three, 3.3.2), initially set for the case-study for any rival explanations (Yin, 2014). However, no rival explanations were identified contrasting with initial propositions. This confirms the internal validity of the case findings from UB.

Chapter Seven- Case Study Three: University C

7.1 Introduction

This chapter discusses the findings from University C (UC), the third case study conducted. A brief profile of UC is presented to provide an anonymous overview of this learning institution. Data collected from, interviews, the focus group and the curriculum review are classified under themes and sub-themes. These main themes concerned the following: conceptual complexities in understanding spirituality; that addressing spirituality appeared to be optional for students and educators alike; issues around authority (including fear of 'getting it wrong'); questions around whether or not spirituality could be taught and the quest for developing shared understanding. Finally, data triangulation based on the findings from three different sources is presented as evidence of the internal validity of the findings from UC.

7.2 Profile

UC has roots as an academic institution in the 19th century. It aims to prepare students to face real world challenges as a response to social mobility and promote employability in community development and business sectors. It has subject speciality in health and business studies. The university is well recognised for its teaching and research innovations.

7.3 Research Findings

Four nursing educators and four student nurses from UC, participated in the research study. The process of accessing and recruiting the educators and nursing students using questing guide in discussed in Chapter Three.

The following themes and sub-themes were also found in UC using template analysis (King & Brooks, 2017). A detailed explanation on how the template was developed and the entire process of data analysis is given in Chapter Four.

Themes which emerged after detailed data analysis are discussed below

7.3.1 Conceptual Complexity

Spirituality was defined as meaning in life, related to personal autonomy and as a force behind personal responses towards loss and pain. From the professional practice perspective, spirituality was seen as caring presence and compassionate care based on common humanity, by both nursing educators and student nurses. To some participants, spirituality was highly related to religious doctrine and associated with fear of hell. Since spirituality was referred to as a private matter, a few participants found it irrelevant to acute nursing care being more relevant to those with a chaplaincy role. They saw its significance only in relation to palliative care. The detailed account on each theme is presented below.

7.3.1.1 Existential Aspects

A few participants related spirituality to existential aspects of human life focusing more on resilience, hope and meaning in life. With reference to patients' preferences and personal choices, a student in the focus group said:

It may be related to activities of daily living, threatening or non-threatening issues. Depends on patients' needs and control, giving choices. (UC-FG/L1524-1525)

Another student added the aspect of existential advocacy as:

It could be mental health issues, responses or referral to be made for. In terms of choices, it has to do with common sense and you need to advocate to initiate that aspect of care for them. We discuss this with mentors. (UC-FG/L1531-1533)

A nursing educator shared his views:

Nurses find it very difficult to assess something they feel very alien, but it is part of nursing assessment. You must actually assess that. In the realm of holism, it is the heart, and in palliative, these issues tend to become more important. Because individual patients become more important. Because [of] those existential questions like meaning in life. (UC-Int 04/L1690-1693)

7.3.1.2 Connectedness

Spirituality was approached as a healing resource which could be used by professionals to enhance recovery by giving patients hope through compassion and empathy. By enabling connection to

patient's own inner self, professionals could promote holistic development in their patients. However, spiritual care aspects were often missed out during clinical practice due to task based interventions:

It's separate or it is part of it... how people feel will effect on their physical care. How they will care about themselves, whether they feel valid about themselves, if they have lost self-worth because they have lost their fertility or limb or their ability to work and that's a huge thing. And nurses think they are the most difficult patients, weeping all the time and not being compliant with medications, and so not picking up the clues... so it has huge impact. (UC-Int01/L2166-2171)

During the focus group, students related connection to the concept of spirituality. One of them said:

Being flexible and tailoring your care to their choice, probably is the best you are going to do. What can I do to help and I don't know to what extent they believe in such things, and I think it would be improper to assume of their background, lives etc. I just have to be listening and accommodating as much as I can. (UC-FG/L1553-1556)

Another student shared:

It is something we do as nurses, we are drawn to nursing, we connect to people, we do it often realising it [is] how we relate spiritual care aspects. (UC-FG/L1535-1536)

7.3.1.3 Religious Affiliation

Participants shared their views about the concept of spirituality as related to cultural values, religious beliefs, death and dying rituals, heaven and with holism in general.

As one educator shared:

Basically, there is multitude of ways... people may think it is coming from a different religious school and its conversion. The definition of spirituality is very open...It is holism and ...can be defined as meaning in life...the word spirituality is very difficult to be defined. (UC-Int 04/1717-1721, 1779-1780)

Another said:

I struggle with that distinction [between religion and spirituality] a little bit and I think in some ways they are sources of anxieties. Death issues, hell and heaven and how they will die. They are more general rather what my life is for. (UC-Int02/L1991-1994)

Students presented contrasting views about spirituality, culture and religion.

One student mentioned:

It's about cultural belief like Sikh have 5 Ks etc. (UC-FG/L1491)

Another student explained:

It is about religion but everyone has sense of spirituality whether they are religious or not. It's not about physical needs, it is about their...kind of self-respect and how important life events are to them. So, in a kind of broader sense... how it may impact this person and how they see themselves. (UC-FG/L1492-1496)

Spiritual care needs were discussed alongside existential health issues: palliative care, death and dying, ritual and the role of chaplains in health care were all discussed. During the focus group study students shared their views:

We have chaplains, so if a patient with a terminal condition needs a chaplain so we arrange. Or if emotional support is required, person-centred care, we would definitely try to be flexible and see what they want. (UC-FG/L1501-1503)

One student mentioned her role in preparing for bathing rituals, as part of palliative care:

Yes, we do like, preparing for last washes... for terminally ill patients. (UC-FG/L1513)

7.3.2 Choice-based

Spirituality was addressed by the nursing educators according to their personal level of comfort and confidence in the subject area. Students viewed spirituality in the context of death and dying rituals and often found a limited personal role in terms of referring patients to chaplaincy care. As one student said:

I don't think so I need to get involved in these, it's a judgment I don't have to make. (UC-FG/L1529-1530)

7.3.2.1 Personal comfort and Creativity

Nursing educators mentioned their role in integrating spiritual care in various aspects of the nursing curriculum focusing on end of life care as:

Yes, I do practical sessions, preparation for practice session on personal hygiene and elimination, individual preference religion wise, around toileting and personal hygiene [from the point of view of] dignity and that would be part of assessment. (UC-Int04/L1739-1741)

Another educator mentioned:

No, I think if we have more clarity, it will make people less anguished in terms of end life care. We obviously have sessions on communication, I don't think spirituality is addressed anywhere else, as far as I am aware. In second year when we do end [of] life, we do cover it. (UC-Int02/L1997-2000)

One educator highlighted that he invites chaplains to teach spirituality to relate nursing care aspects with spiritual care. He shared that:

We teach it very broadly and not equating it with organised religion. One of the chaplains is invited as well for two and half session, to discuss spiritual care needs of patients. (UC-Int02/L1954-1956)

Another educator explained his teaching strategy as:

In the sense of holism and the area that I teach, I definitely bring [spirituality] in from the holism perspective. So, students actually ask and assess for spiritual need. Spirituality and religion, I found very different themes, especially in the contemporary world, where people are actually involved in secular sciences and actually grabbing pieces what suits them. Most people they don't feel comfortable to discuss these issues. But I think it should be still assessed and it is part of our nursing care area. (UC-Int04/L1671-1676)

Educators' interests, individual competency and care priorities determined how spirituality was treated in nursing education.

A student in the focus group also related spirituality to end of life care:

When we did dying and end of life care, how body is dealt, relative or sensitive time near dying. (UC-FG/L1479-1480)

For students, addressing spiritual care needs in clinical practice was seen as a matter of choice-based on care priorities.

It is important to have an assessment on it [Spiritual need]. But these are unlikely that I am going to ask if the patient comes into A&E. (UC-FG/L1522-1523)

7.3.2.2 Time and Environment

The priority of the disease-based approach over person-centred care, and the role expectations due to the empirical nature of nursing practice, time constraints and the environment were identified as major challenges by the participants.

One educator mentioned:

I think it's saying too much of holistic and care but people really need to think about really caring about, very strange and wonderful and civilised concept. It's easier to tick off for organic things than to sit with some body...so it would be nice to put it back in. So, one side is completely flung from nursing - the whole person - and this need to come back! (UC-Int01/L2173-2177)

Another educator identified challenges to spiritual care needs in education and practice:

It [Spirituality] is nebulous so how would you objectify [spiritual care] - that is very difficult. People are denied spiritual care, because it is not addressed at all. And practically it is not possible from religious perspective, especially if you are in hospital. You could have one chaplain, or one imam and people are dying every minute, so again you need a team...and how can nurses be prepared to deliver care in spiritual way... But there are a lot of questions unexamined from practice point of view as well, both from education gaps as well, huge number of gaps. (UC-Int04/1755-1764)

During the focus group, when environmental factors were explored, students were well aware of the challenges:

But then you need to have time to talk [about] these things in length.

(UC-FG/L1504)

Another student shared:

You can never spend enough time with the patient. At the end of the day you are never satisfied...I think nursing is all about doing what you can in the given time and resources. (UC-FG/L1508-1510)

The priority of disease-based care over person-centred care was discussed by one student:

I think there are things depending on the phase or areas, a bit of medical treatment gets started until you identify a reason or cause to think about spirituality. Other things in patient's life, their community, social life etc. are there, but when they [patients] come in [hospital] there are another need - priority medical. (UC-FG/L1514-1517)

7.3.2.3 Non-Explicit in Nursing Curriculum

With reference to spirituality, participants shared concerns emphasising the need for an explicit representation of spiritual issues in the nursing curriculum.

One educator pointed out his concerns that the nursing curriculum did not mention spiritual competency and lacked clarity for educators:

Yes, there is no competency out there. There are RCN guidelines on spirituality and staying in-line with dignity, respect but there is no framework out there for actually how you teach them. I did my Masters 10 years ago, and I looked for any framework and there isn't there. Particularly in multi-cultural society in London...the most diverse community in the world probably, but there is no framework, so I think how it is displayed in education, is holism. (UC-Int04/L1696-1701)

Another educator inquired:

Does NMC talk about spirituality? I am trying to think. It is absolutely shameful. (UC-Int02/L2003-2004)

One educator shared his teaching strategy as discussing spirituality at different levels while planning the end of life care module; as:

So, what we do then once after beginning the module on end of life care. We have reflective sessions...to explore the other aspects they could relate it to meaning, within their own lives, how they can help others, we do integrate it with symptom management, physiotherapy care, how it relates with spirituality, as part of their learning. (UC-Int03/L1803-1806)

Another educator mentioned the role of mentors at clinical placements in preparing students to develop skills and knowledge for required competencies as set by NMC standards.

It's been assessed by mentors at practice..., so they have specific competencies within the pack related to NMC guide lines. They utilise that to assess to see their communication and interaction while maintaining dignity and privacy. (UC-Int03/L1814-1818)

Students shared their learning experiences of spiritual care issues in palliative care and transcultural care:

Cultural and religious aspects are generally discussed related to end of life care. We learn effective communication and different belief systems which constitutes person-centred care. (UC-FG/L1484-1486)

7.3.3 Question of Authority

Participants asserted their anxieties in relating to the concept of spirituality in a multicultural society and their fear of causing offence or being misunderstood by others, due to diverse values and belief systems.

7.3.3.1 Fear

There was an underlying fear of offending others particularly with reference to a multicultural society.

An educator shared their worries:

No, no, there is person- centred care but nobody wants to use that word [spirituality] as they feel scared that it will look like religion and that you are imposing some dogma on people. There are things in RCN, but they are so many different worries and bullies..., even more difficult in more multicultural and multi-faith societies, it's perhaps easier in mono-cultural and mono-faith societies, to be upfront about things. But we are a bit worried about people complaining, people saying that somebody has bought their opinion or views to something.
(UC-Int01/2099-2106)

Another source of fear was rooted in lack of knowledge, clarity and having the authority to discuss spiritual care perhaps because of religious beliefs:

I personally feel very conflicted about it; I am being very honest. My personal background is a Christian, but if you are liberal and you may have your own understanding... its very subjective belief. I don't feel that authority, feel very uncomfortable talking about these. (UC-Int02/L1959-1962)

7.3.3.2 Role confusion

Due to concerns about authority issues with respect to a given belief or faith, some participants found it confusing to relate spirituality to nursing. A nursing educator said:

I think spirituality is a difficult concept for people and has different meanings to different people as well. So, it depends. I found it very interesting when I asked my students, what they understand by spirituality. Often, they link it very closely to religion and not necessarily explore it. Perhaps it is more related to meaning and exploration rather [than] just religious aspects. So, some find it a difficult topic to address because of their own religious belief, they find it an uncomfortable area to explore with patients. Because they feel they don't know what

the right answer is, especially in end of life care, palliative care. There are so many emotions within that arena, ...perhaps they are almost confrontational. (UC-Int03/L1796-1801)

Another educator highlighted that the role ambiguity for educators in relating spirituality to nursing education; was rooted in the curriculum structure:

Because people are afraid of this, students, nursing educators and multidisciplinary staff are afraid to use the language. When I introduced some of my participants I actually said that I would be afraid to ask questions about spiritual care needs, because it could offend people... There needs to be work done. And how to fit into the curriculum in contemporary society is another question. (UC-Int04/L1710-1714)

A student shared her experience focusing upon the nature of anxiety spirituality carries with itself as:

Differs from patient to patient and nurse to nurse. If nurse is Catholic and patient is non-Christian or if it's me I won't go praying with a patient. It's not me saying no to that example of bad nursing but I will arrange someone else. A) I don't believe in it so it is not being honest. B) I don't feel comfortable being part of that ritual, as I don't have any concept of that. So, it's like dishonesty and it will be more meaningful, if both of us could actually carry the same belief. ...I don't know what to do in such situation. (UC-FG/L1540-1545)

7.3.4 Spirituality Can/Cannot be taught:

Several views were reported when asked whether spirituality can be approached through formal teaching or learning sessions. The details are presented below.

7.3.4.1 Vocational based

Some students asserted that since spiritual care is rooted in personal values and compassionate care, it could never be taught formally. For example, during the focus group one student stated:

I recognise the value of it based on nursing values, respect etc. It is not a skill aspect. (UC-FG/1548-1549)

Another student mentioned personality factors:

Your own personality comes in how you deal with a situation and time constraints. Can't be any formula but depends. I feel like I can have conversations on this and some of patients are

very inspirational. Some patients have very strong spirits and it comes across as encounter.
(UC-FG/L1647-1650)

7.3.4.2 Quest for developing a shared understanding

Participants emphasised the need to do more research and to integrate spirituality into education:

... huge need for research across the whole health care and then how you put in health system...I think we need an educational framework to treat the patient as an individual in a multicultural society. How you best assess, plan, evaluate and what are your duties, and you actually be prepared to individualise answers but you are not actually prepared to. But there are not clear guidelines from educational or practice level across the board, it's done as laissez faire. Tick the box. It is not looked at deeper...so that you can [find] deeper dialogue and deeper knowledge for education and opening that dialogue. (UC-Int04/L1754, 1767-1779)

It was suggested that more discussion on the shared understanding towards spiritual care and wellbeing should be encouraged. Participants asserted that that due to difference in ideology, faith systems and religious doctrine, spirituality has often been seen to present a threat of giving offence or to be a source of conflict, particularly with reference to choices related to end of life care issues. One interviewee recommended that:

It is very important and we need to make it more central to our curriculum. My feeling is that almost like we are mixing it all together with culture and people. But when we come to think about scriptures, we get stuck due to differences. People are slightly aware, as we should be. So, there are people who are happy to talk about it and they should be encouraged to bring it forward. I also feel that it's my right not to talk about it, because it is painful. (UC-Int02/2026-2033)

Another educator emphasised that educators themselves should get mentorship and training to explore their own spirituality. That's how educators could be prepared to understand spiritual care needs of their students too and facilitate students to be competent in spiritual care:

No, I think people get quite scared of that. People are scared due to boundary issues, like one Christian person prayed for some body and was objected so they haven't quite learnt how to

deal with that. RCN emphasis on socio-spiritual care but I think there is also a problem that staff themselves do not get spiritual care and they need it. (UC-Int01/L2070-2074)

Participants also discussed time constraints, work load balance and nursing role expectations. Only with attention to these issues could person-centred care be optimised without any compromise to acute care priorities:

I think spirituality is very necessary and it forms patient's choice. How people choose to take health care and what is being healthy for them. But it is time to apply [this] with each patient, large assessments on each patient, it is very very difficult. (UC-FG/L1519-1521)

Another suggestion was to reduce paper work and focus more upon therapeutic communication to enable spiritual care:

Empathy, listening, letting them be themselves, ultimate form of caring, not being tasks or goal orientated. We used to do therapeutic communication, but now everything is about doing ticks. Just need to be about giving people space, may be reducing paper work load. (UC-Int01/L2142-2145)

Since spirituality had not been explicitly acknowledged in the latest NMC code (2015), nursing educators identified this as a challenge.

...we have communication skills, and team working, multicultural team, NMC competencies, may be embedded in person-centred care but nobody really wants to put that word [spirituality] in...probably would be easier if it could be more explicit rather than more implicit. (UC-Int01/L2114-2118)

7.3.4.3 Framework for teaching and Practice

Educators expressed the need for a standardised teaching practice to integrate aspects of spiritual care in nursing education without any role confusions or anxiety. For example, one educator raised this:

We have module descriptor, which gives the outline of the basic component of the module. There are competency headings. No descriptions, its more how you adopt to do yourself, ensuring that spirituality is intrinsic to a thought and how you apply that. And I am sure in more Universities it is more descriptors rather than a more definitive way. That probably would not

be right. It may lead to variances in how it is delivered. I suppose you can describe it more factually, by giving definitions. (UC-Int03/L1869-1874)

An educator with an interest in end of life care pointed out:

I think I may improvise in a sense how to teach it. Because I am in speciality area, so I have to do reading but lot of people won't. So, it won't come in the vocabulary, it won't come in discourse, it won't come into dialogue to assess. And in general, in the hospice, it is there because of the holistic philosophy behind. It is one of the element it says, and it is for NMC but I don't see. (UC-Int04/L1704-1708)

7.3.5 Curriculum Review:

Two Course grids for BSc Yr. 3 nursing courses were reviewed along with the undergraduate hand book for exploring the assessment criteria set by UC; to assess students' competency and skills development to address spiritual care need.

7.3.5.1 Findings

UC used modules for teaching each course in the undergraduate nursing curriculum. In each module spirituality was identified implicitly or explicitly in curriculum documents threaded with different nursing components under person-centred, holistic care, spirituality and wellbeing and in reflective practices. However, no knowledge or skill based assessment criteria were found to assess competencies required to understanding and addressing spiritual care need. A module specification where spirituality was integrated explicitly or implicitly (as mentioned by the participants), is illustrated in table 13 below.

Table 13: Curriculum Review- UC

Name of Module	Themes in Module where spirituality is explicitly or implicitly integrated
Providing Support Across the Lifespan	1. End of life care 2. Cultural and religious beliefs
Complex and High Dependency Care of Children	1. Privacy and dignity 2. Person-centred care
Advanced Therapeutic Effectiveness	1. Communication and Interpersonal skills 2. Professional values
Rehabilitation and Health Promotion of the Adult	1. Privacy and dignity 2. Person-centred care

Nursing educators at UC looked for increased clarity by revising the curriculum structure, both institutionally and through national nursing bodies like RCN and NMC. Also, recognising the teaching limitation due to the modular structure of nursing curriculum; a teaching framework on spirituality was strongly recommended by the educators. Educators also highlighted the need for mentorship programmes for themselves that could enable them to explore their own spirituality and facilitate students in self-exploration. Such reflective practices can promote confidence and competency in student nurses to understand and address spiritual care need of their patients without role confusion or underlying fear of breaching professional boundaries.

7.4 Data Triangulation for UC

UC presented a blend of specialised and nonspecialised faculty with scholarship in teaching spirituality and chaplains teaching nursing courses. A few nursing educators, depending on personal experience and interest, discussed spirituality across the themes of palliative care, self-care and ethics. Some nurse educators related spirituality to death and dying rituals for terminally ill patients. There was transcultural approach to teaching and an emphasis on valuing diversity of faith systems by educators. Similar data were gathered from students through the focus group.

Spiritual care components were approached with reference to patients' choice, control and dignity factors. Students did recognise spiritual care as a core philosophy of nursing care but believed that it could not be taught through formal teaching since it could not be classified as a nursing skill. From the competency development perspective, insight could be nurtured in students through experiential learning rather than classroom teaching. However, students also emphasised that more exploration and discussion about spirituality should be part of their lecture sessions or small tutorials.

Both nursing educators and students recognised that NMC standards were too broad to articulate spirituality in nursing and there was a need to have more clarity and specification in this regard. Often in the name of person-centred care, religious beliefs and personal choices, both students and educators tended to refer their patients to chaplains for specialised spiritual services. Spiritual care was not always recognised as a legitimate nursing role, especially in acute clinical care setups. Also, due to lack of confidence and fear of causing discomfort or offence, educators and students reported they confined their spiritual care to acknowledging religious beliefs and providing preference to privacy, personal choices and dignity during teaching and care giving practices. Data findings were matched with the propositions (Chapter Three, 3.3.2), initially set for the case-study for any rival explanations (Yin, 2014). However, no rival explanation was identified contrasting with initial propositions. This confirms the internal validity of the case findings from UC.

Chapter Eight- Case Study Four: UD

8.1 Introduction

This chapter discusses the findings from University D (UD), the fourth case study conducted. A brief profile of UD is presented to provide an anonymous overview of this learning institution. Data collected from one interview with an educator and a review of curriculum documents, were analysed using the template analysis derived themes and sub-themes. The main themes were as follows: conceptual complexities in understanding spirituality; addressing spirituality appeared to be optional for students and educators alike; issues around authority (including fear of 'getting it wrong'); questions around whether or not spirituality could be taught and the quest for developing shared understanding. Since these cases could not present the complete data sets, only available details are shared here. A summary of the findings based on UD is presented at the end of the chapter.

8.2 Profile

This university also had its roots in academia from the early 19th century. The university is an established teaching and research institution with many campuses internationally. UD has remarkable achievements in medicine and science. The university sees itself as offering high quality education and pioneering research and innovation.

8.3 Research findings

Only one interview from a nursing educator at UD was recorded. Since students were busy in their exams and clinical rotation, no focus group study could be planned in the given time frame. Despite offering several alternatives to both educators and student nurses, it was not possible to access and recruit adequate number of participants to conduct the full study at UD. Chapter Four discusses the access and recruitment issue at UD in detail. Although, curriculum access was granted at UD however, with one interview from nursing educator, the data was not sufficient for UD to be considered as a complete single case study.

The following themes and sub-themes developed from the template analysis (King & Brooks 2017) were examined at UD. A detailed explanation of how the template was developed and data analysis conducted is given in Chapter Four.

Themes which emerged after detailed data analysis are discussed below.

8.3.1 Conceptual complexity

The nursing educator shared her views on spirituality by focusing on existential aspects. No other data was found under this theme.

8.3.1.1 Existential aspects

Based on the nursing educators' professional experience in mental health, she related spirituality to recovery and the identity of a person:

To me it [spirituality] is related to recovery and philosophy which is very much recognising the impact of mental health, a person's identity in life and how we as nurses help them [patients] in recovering that aspect of life. (UD-Int01/L2208-2210)

8.3.1.2 Connectedness

No data were recorded under this sub-theme.

8.3.1.3 Religious Affiliation

No data were recorded under this sub-theme.

8.3.2 Choice-based

Limited data was gathered under this theme as follows.

8.3.2.1 Personal comfort and creativity

UD has developed a specialised guide and online resources for both educators and students to integrate spirituality in nursing education:

We have lead lecturers and facilitators, not necessarily subject experts, but we have got a guide to support that.(UD-Int01/L2193-2194)

On a blended learning course, the educator shared that:

It is module in our programme through a blended learning approach. Lectures and facilitation is provided in seminars. (UD-Int01/L2197)

And added,

We used a blended online learning blog on questions on spirituality and its role [and the] difference between spiritual and psychotic beliefs. And that [seems] quite useful.(UD-Int01/2260-2262)

8.3.2.2 Time and environment

With reference to time and work load, it was asserted that:

Depending on where people are. Personal reflection is there but then actual pressure is there. Mental health assessments are holistic but there are limitations due to time considerations but the recovery unit is providing more space and spiritual side of it in terms of community rehabilitation etc.(UD-Int 01/L2249-2252)

8.3.2.3 Non-Explicit in Nursing curriculum

The nursing educator emphasised that more clarity was required from the NMC on integrating spirituality as a legitimate aspect of education and care competency:

... it is difficult and your modules are quite detached. There should be more understanding towards it [spirituality]. The NMC talks about spiritual needs but it would not say how or what we need to get to things on the right path. There are always challenges about how we keep a balance in perspectives. Biology side of care, but these are barriers to learning, what is more concrete knowledge, accessible vs what is experiential, emotional, philosophical and hard to grasp, and what is there for me as a nurse.(UD-Int01/L2215-2220)

8.3.3 Question of Authority

A challenge of teaching spirituality in multicultural environment was identified as:

Sometimes, because of diverse and personal belief, it [teaching spirituality] can be uncomfortable, or sometimes due to lack of knowledge it becomes challenging. Occasionally

we have very strong different views and it is difficult in large groups with international perspectives. (UD-Int 01/L2201-2204)

8.3.3.1 Fear

No data found under this sub-theme.

8.3.3.2 Role confusion- Nurses or Chaplains

No data found under this sub-theme.

8.3.4 Spirituality can/cannot be taught:

Limited sub-themes were identified under this theme.

8.3.4.1 Vocation-based

No data found under this sub-theme.

8.3.4.2 Quest for developing shared understanding

The nursing educator emphasised that spirituality should be recognised as an essential aspect of care priorities. It was asserted:

Perhaps equal visibility of spirituality in NMC like other traditional subjects like, biology for required competencies. There is a possibility how policies and definitions can provide holistic perspectives. I think narratives and looking at people's experiences, journeys of distress and disability can become their priorities of care (UD-Int01/2228-2231).

8.3.4.3 Framework for teaching and practice

The nursing educator highlighted that for this subject a special guide was being prepared to support the other teaching staff after the person who previously led in this area had moved on:

We used to have AA's (pseudonym) work and he used to do a lot of direct teaching and developing people's' confidence. They did some training around this before, as well; but it is quite variable among educators. (UD-Int01/L2206-2209)

The educator felt that there was a need to develop an evidence-based approach to assessing competency in spiritual care:

NMC assessment for competency is there. There is one on reflective care which may impact on spirituality... Often there is a confusion between religion and spirituality. But this is not a practice based or evidence based competency. So, students do require evidence based assessment. (UD-Int 01/2234-2238)

8.3.5 Curriculum Review

Along with course modules for each unit, a specialised course template had been developed for teaching spirituality both for face-to-face learning and blended learning at UD. However only one course grid on mental health nursing for the BSc Yr. 3 nursing course was accessed and reviewed.

8.3.5.1 Findings

Spirituality was integrated both implicitly and explicitly in curriculum documents threaded with different nursing components under person- centred, holistic care, spirituality and wellbeing and in reflective practices. Also, based on online and face-to-face tutorials and seminars, was provided at UD to nursing educators and students. A modular representation of each course with theme specification where spirituality is discussed; is illustrated in table 13 below.

Table 13: Curriculum Review- UD

Name of Module	Themes in Module
Mental health	<ol style="list-style-type: none"> 1. Hope and Meaning-making 2. Dignity and privacy 3. Person-centred care 4. Transcultural health care 5. Mindfulness

8.4 Data Triangulation for UD

Due to the unavailability of research participants and limitation of access to relevant curriculum documents, inadequate information was gathered from UD. This incomplete case study fails to establish internal validity checks for rival explanations, as data triangulation cannot be performed on the basis of inadequate data collection from potential sources (Yin, 2009). UD was not included in the final multiple case study analysis (Chapter Ten).

8.5 Case Summary

The sole interviewee in UD focused on NMC policies and curriculum structures, and believed more discussion was required to bring innovation in nursing education. UD offered significant support to student and faculty members. A specialised course guide and a student blog on spirituality was part of their nursing programme to develop competence and confidence in responding to spiritual care needs. UD recognised the integration of a transcultural approach with aspects of spirituality and religion.

Chapter Nine- Case Study Five: UE

9.1 Introduction

This chapter discusses the findings from University E (UE), the fifth case study conducted. A brief profile of UE is presented to provide an anonymous overview of this learning institution. In UE data were only collected from the focus group and they are presented as themes and sub-themes. The main themes concerned the following: conceptual complexities in understanding spirituality; that addressing spirituality appeared to be optional for students and educators alike; issues around authority (including fear of 'getting it wrong'); questions around whether or not spirituality could be taught and the quest for developing shared understanding. Since UE could not present the complete data sets, only available details are shared here. A summary of the findings based on UE is presented at the end of the chapter.

9.2 Profile

This university considers itself a modern university and was established in the 20th century. It aims to develop education, employability and entrepreneurship among its international students. The university has remarkable achievement in research sciences across health, technology and social policy. It aims to empower students and transform their lives through innovative learning experiences.

9.3 Research findings

There was no participation from nursing educators for this study. Since students were busy in their exams and clinical rotation, only two student nurses participated in focus group study. Despite of offering alternative appointments and arrangements there was no success in accessing and recruiting further participants. Chapter Four discusses the access and recruitment issue at UE in detail. No access to curriculum was granted at UE. However, based on the data recorded from the focus group study; the following themes and sub- theme were developed using template analysis (King & Brooks,

2017) and applied to data from UE. A detailed explanation on how the template was developed and the entire process of data analysis conducted is given in Chapter Four.

Themes which emerged after detailed data analysis are discussed below.

9.3.1 Conceptual complexity

Students saw their professional role as student nurses and their commitment to holistic care as embracing spirituality competent practice.

9.3.1.1 Existential aspects

Students related spirituality to nursing care philosophy and linked it with holistic care.

We choose to be nurses and providing holistic care it part of nursing care and care philosophy. I think it [spiritual care] is about our passion to be there for patients. (UE-FG/2270-2272)

9.3.1.2 Connectedness

Students saw compassionate care as an expression of connectivity with patients while explaining what they understood as spiritual care practice. One student shared:

it's the caring presence of a nurse and compassion that enables us to understand person-centred need. (UE-FG/2300-2301)

9.3.1.3 Religious Affiliation

One student saw spirituality as related to personal religious belief but at the same time recognised that person-centred care respected the patient's beliefs.

To me its [spirituality] is my religious belief. I can't separate the two concepts. It's my belief but we have to provide person-centred care based on their beliefs. (UE- FG/2276-2278).

The other student also nodded head and affirmed this.

9.3.2 Choice-based

Students shared their experience and related spirituality to compassionate care and therapeutic listening, which was largely influenced by work load and environment.

9.3.2.1 Personal comfort and creativity

No data were recorded under this sub-theme.

9.3.2.2 Time and environment

During the focus group study, students from UE highlighted time and work-load issues:

Due to time and work load pressure, it is difficult to offer person-centred care during Emergency care setups. In community, it is easier to integrate psycho-social aspects. We perform in-depth assessments and involve family members in learning disability unit. Its more [normal] practice to offer choice-based care in community nursing. (UE-FG/L2270-2274)

9.3.2.3 Non-Explicit in Nursing curriculum

No specific data was found under this sub-theme.

9.3.3 Question of Authority

At UE, students approached spirituality from transcultural and religious perspectives:

Guest speakers from other faiths were invited to talk about different belief systems, that's how spirituality was discussed in our class. (UE-FG/2267-2268)

9.3.3.1 Fear

For students, spiritual care aspects were as the same as person centred care. Hence, no specific data was found under this sub-theme.

9.3.3.2 Role confusion- Nurses or Chaplains

No data found under this sub-theme.

9.3.4 Spirituality can/cannot be taught:

Student shared their learning experiences as mentioned that:

We discuss spiritual and cultural needs in large class room. But no special tutorial or clinical are provided specifically on this [Spirituality]. ((UE-FG/2260-2261)

9.3.4.1 Vocation-based

No data found under this sub-theme.

9.3.4.2 Quest for developing shared understanding

Students shared that it's the cultural and religious aspects which are mostly emphasised in class room teaching. However, they would like to know more about philosophical aspects related to spirituality and wellbeing.

Nursing philosophy, healing and rehabilitation are some areas where we would like to have more lectures. (UE-FG/2280-2281)

9.3.4.3 Framework for teaching and practice

No data found under this sub-theme.

9.3.5 Curriculum Review

No access to curriculum document was granted at UE.

9.4 Data Triangulation for UE

No data triangulation was possible due to the unavailability nursing educators and declined access to relevant curriculum documents. Inadequate information was gathered from focus group study. UE, as a single case study fails to establish any internal validity checks for rival explanations, or pattern matching through data triangulation (Yin, 2014). UE was not included in the final multiple case study analysis (Chapter Ten). However, a case summary is presented below.

9.5 Case Summary

UE recognised the integration of a transcultural approach with aspects of spirituality and religion. Based on personal interest, the two students wanted to know more about philosophical aspects of spiritual care. Spirituality was approached from cultural and religious perspectives by inviting guest lecturers from different faiths. Students identified that more support from nursing educators was required especially during clinical placements, to understand person-centred need.

Chapter Ten: Synthesis of findings from main cases. (UA, UB, UC)

10. 1 Introduction

To establish reliability and to draw as many conclusions as possible from the research, a cross theme synthesis discussing the similarities and differences of findings across all cases is presented in Chapter Ten. This is the main findings chapter based on multiple case study analysis of the three complete cases. Following Yin's (2009) case study analysis techniques, a cross-case synthesis of the cases will be presented here to achieve findings that seek to be as robust and unbiased as possible, by establishing external validity (Yin, 2009; Yin, 2014; Robson & McCartan, 2016). After presenting an overview of the similar and contrasting findings across all cases, findings will be discussed according to the themes and sub-themes derived from the template analysis.

10.2 Cross-case synthesis

After analysing all five single case studies, findings from three complete cases were compared to develop a cross-case synthesis for literal and theoretical replication (Yin, 2009). The themes generated from the template analysis were examined in the light of the initial propositions discussed in Chapter Three. The themes and propositions were critically examined in the light of the literature and possible rival explanations. No rival explanations were found in Case Study A, B and C, hence the internal validity of all three case studies is achieved. The reliability and external validity of the main findings will be established through the process of, "convergence of evidence" in this chapter (Yin 2009, p117). The following sections will summarise evidence for literal and theoretical replication between the cases. Initially, brief summaries of the main findings in each case will be presented with notes about where the findings from each case supported each other and notes about where they differed. For example, only one or two cases may have had evidence of a particular finding. This could be summarised as evidence of literal and theoretical replication as well as features unique to each case. Literal and theoretical replication are regarded as evidence of external validity (Yin 2009; Robson & McCartan, 2016). Unique features also present opportunities for learning (Yin 2009, 2014).

10.2.1 Case Study A-UA

UA was found to have significant multidisciplinary structures to promote research and implementation of spirituality in health education. Various teaching, research and scholarly opportunities were offered by the institution, especially regarding nursing education. A distinctive feature of this case was the establishment of a multidisciplinary spirituality special interest group, founded by a group of staff including two senior nursing educators. This offered support and confidence to staff and students in relation to approaching spiritual care through continuous research and scholarship. In addition, members of the spirituality interest group were approached by staff for specialised teaching support on spirituality. This practice was only found in UA, as in other cases formal teaching on spirituality was not part of standard practice. However, UC was offering a few teaching sessions on spirituality through liaison with Chaplaincy services.

Whilst the term 'spirituality' was not necessarily used, its relevance was acknowledged by other nursing educators when teaching about mental health, professional practice and leadership, reflective practices and learning disability. Spirituality was acknowledged as a core component of holistic care during classroom learning and clinical tutorials. UC presented a similar finding of relating spirituality to all subject areas.

In all three cases, both students and nursing educators identified a need to develop more clarity and shared understanding around the concept of spirituality. There was no explicit mention of spirituality in the Nursing and Midwifery Council Code (NMC, 2015). Person-centred and compassionate care, which are mentioned in the Code, can be assumed to include spiritual care but there is no obligation to make this assumption.

During curriculum review, it was found that UA followed a modular approach for teaching the undergraduate nursing course. A specific course outline with syllabus outline, highlighting spirituality as a recognised theme was developed. A similar curriculum structure was found in UC, where all units and modules were found very aligned and mapped across several themes. However, in UB only a brief overview of each module was presented.

Although UA supported the integration of spirituality in nursing education, the modular nature of the nursing curriculum, resulted in it being left to individual educators' choices and creativity as to how this was achieved in practice. UC also identified the gap in nursing knowledge and practice, due to the modular nature of the existing nursing curriculum and emphasised the need for a teaching

framework to develop a shared understanding on how to present spirituality in nursing education. UB, however could not comment on the structure of the nursing curriculum; considering spirituality as a non-specific embedded concept of holistic care and fulfilling the NMC progression criteria.

Participants at UA, acknowledged the importance of personal experiences and recognised the importance of reflective practice to develop self-awareness and professional competency in the area of spiritual care. They recognised this could be facilitated by mentoring. Educators can also facilitate and encourage dialogue in small group settings to address fears and anxieties associated with the term spirituality, especially with reference to clinical workload and time pressure. UB and UC supported these findings and emphasised self-awareness and compassionate care through mentorship support.

10.2.2 Case Study B- UB

UB presented some significant findings; reflecting the structure of learning in this university's undergraduate nursing programme. During curriculum review, the key finding was that UB did not follow any detailed module guide to structure the learning course, unlike UA and UC. Due to the flexible nature of the teaching ethos, not only the teaching and learning strategies but even the course guide was kept open, under the NMC progression requirements. No syllabus outlines or unit specification was found developed as a curriculum document. Owing to the flexible learning practices and the structure of teaching, it was not possible to access educators involved directly in teaching, at UB. The recruited research participants were the permanent nursing educators and were programme lead facilitators for undergraduate nursing education. However, they were not involved in direct class room or clinical teaching. Hence, no data were gathered from educators identifying the practical challenges or extent of integrating spirituality in nursing education. No evidence was found of any specialised teaching or special interest group relating to spirituality in UB.

Nevertheless, UB presented some similar findings to UA and UC including the need for more explicit integration of spiritual care in nursing education. Also, similar fears and anxieties were mentioned by students in clinical settings based on differences in values and beliefs, as these were perceived to be a part of spiritual care and the desire to respect religious belief. Students also identified time and work load pressures, influencing their care resulting in inadequate therapeutic encounters with patients.

In general, a quest for more competency was highlighted by the participants to have more clarity and support in developing understanding of spirituality in nursing education.

10.2.3 Case Study Three- UC

UC, presented some interesting findings in comparison to the other case studies. Unlike UA and UB, in Case Study C spiritual care education focused on palliative and end of life care. In palliative care, the students' role in providing spiritual care was mainly in signposting specialised services like chaplaincy care and facilitating end of life rituals. Chaplains were involved in teaching sessions to cover religious and spiritual care needs regarding end of life care. UC, participants were particularly concerned with fears and anxieties related to working in a multicultural society, especially with reference to dying rituals and the ambiguity of the nursing role in relationship to chaplaincy care. Similar to UA and UB findings; both students and educators at UC shared their concerns regarding time and work load pressures due to priority being given to disease-centred approaches over person-centred care. UC, too, reflected the need for more clarity about addressing spiritual issues from the NMC. A need to develop shared understanding among the academic faculty members was identified. The staff teaching undergraduate courses were from various backgrounds ranging from a professional background in chaplaincy and academic qualifications in spirituality to no previous experience of teaching spirituality. Hence, some nursing educators felt confident and competent enough to address spirituality in taught nursing courses, while others shared their fears and confusion based on personal experiences and values. Nevertheless, all educators emphasised the need of more explicit integration of spirituality in NMC documents. The curriculum was modular and open to personal choices and creativity in teaching approaches and whether or not spirituality was addressed in areas other than palliative care.

10.3 Thematic findings

As a result of the template analysis four main themes were finally identified. For clarity, the final themes are illustrated through diagrams as well.

10.3.1 Conceptual complexity

Interviewees saw spirituality as an overarching concept that was very abstract and difficult to define but which related to ideas such as holism, the inner self and belief systems. One educator from UA discussed these issues:

Depends how you define spirituality. For me it isn't just about culture and religion and those kinds of things...It is very difficult to define spirituality. People go down to religion or culture...at times related with being Asian, being Muslims or Buddhist, but in a way, we all are spiritual regardless of cultures or religion. A loss or grief is to do with spirituality...I feel, but heaven... not everybody believes that. (UA-Int 06/L207, 215-218)

No data was reported by the educators from UB about whether they found conceptual complexity associated with the term of spirituality. This was largely because there was little use of the specific term 'spirituality' which was assumed to be contained in the overarching concept of 'holistic care'. However, one educator from UC shared concerns about the difficulty in defining spirituality:

Basically, there is multitude of ways... people may think it is coming from a different religious school and its conversion. The definition of spirituality is very open...It is holism and ...can be defined as meaning in life...the word spirituality is very difficult to be defined. (UC-Int 04/1717-1721, 1779-1780)

Another educator from UC discussed similar issues:

I think spirituality is a difficult concept for people and has different meanings to different people as well. So, depends. I found it very interesting, when I asked my students, what they understand by spirituality. Often, they link it very closely to religion and [do] not necessarily explore it. Perhaps it is more related to meaning and exploration rather [than] just religious aspects. So, some find it difficult topic to address because of their own religious belief and they find it uncomfortable area to explore with patients because they feel they don't know what the right answer is, especially in end of life care, palliative care. (UC-Int 03/L1792-1799)

During the focus groups, across-cases, students also mentioned the conceptual complexity:

The way spirituality was brought it in lecture, it was not just religion, it was at person level. We need to explore it on wider understanding with person's core belief, that's my understanding.
(UA-FG/L18-20)

At UB a student while discussing the complexity in relating spirituality to religion highlighted contemporary changes in social attitudes towards spirituality:

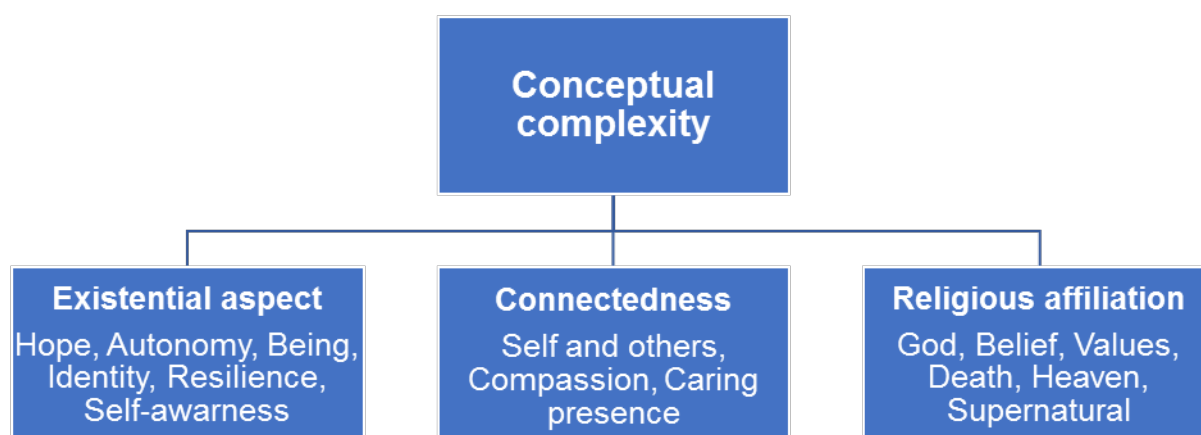
What was the meaning of religion as in olden days we used to think, it's much more than that. (UB-FG/L1464)

A student from UC explained the complexity in relating spirituality from multiple perspectives as:

It is about religion but everyone has sense of spirituality whether they are religious or not. It's not about physical needs, it is about their...kind of self-respect and how important life events are to them. So, in a kind of broader sense... how it may impact this person and how they see themselves. (UC-FG/L1492-1496)

Several embedded sub-themes were also identified while exploring the perception of participants on spirituality. Figure 1 illustrates sub-themes. These sub-themes were classified as follows:

Figure 1: Theme One- Conceptual complexity



10.3.1.1 Existential aspect

Spirituality was described as a core value that marked the individuality of each person. Spirituality was also explored as an existential resource. Regarding self-healing, effective coping and self-actualization, spirituality was recognised as being at the core of nursing practice to enable holistic development.

It was seen as one aspect defining a person as a unique being with a unique personal identity.

Spiritual care was about helping people reach their full potential as emphasised by an educator from UA:

To me, spirituality is about people reaching their full potential, in terms of their own spiritual wellbeing. Therefore, as Learning Disability nurses, we teach people with Learning Disability to reach their full potential they aspire for. That's what I teach students to do - encourage the clients to be who they want to be really, and look for the way. (UA-Int 06/L207-212).

Another educator from UA, acknowledging the difficulty in approaching spiritual care, explained how spirituality could be understood as an existential resource providing hope and meaning:

The fact that spirituality is a difficult concept for clinicians to understand so, my definition of spirituality is innately human. Giving hope, meaning and person-centred care...to mediate through availability and vulnerability, two ways of working to operate spirituality. (UA-Int 03/L803-806)

Educators from UB related spirituality strongly to holism, as one said:

I think my impression on spirituality would be really looking at holistic person. (UB-Int 01/L536)

A nursing educator from UC also related spirituality to holism by focusing upon meaningfulness:

Nurses find it very difficult to assess something they feel very alien, but it is part of nursing assessment. You must actually assess that. In the realm of holism, it is the heart, and in palliative, these issues tend to become more important. Because individual patients become more important. Because [of] those existential questions like meaning in life. (UC-Int 04/L1690-1693)

In the focus group at UA one student expressed a similar understanding succinctly:

The essence of yourself, the key thing I remember from one tutorial. (UA-FG/L23).

Regarding personal identity and choice-making, spirituality was also defined by one student contributor at UA as a person's freedom to recognise their own sexual needs, overcome sexual inhibitions, voice fears and experience mindfulness through sexual practices.

(Spirituality is) ... I guess it was hard to explain really. Younger generation now take it differently. One thing I relate it to is peoples' sexuality... you never say sexuality is not traditional, hard to word it but there are lots of things changing. it's an essence of yourself, if you see yourself attracted to a woman, that is part of my spirituality of who I am. I would not consider this religious but spiritual. To me sexuality is linked to my spirituality. Its considered wrong in religion. Lots of people don't link sexuality with religion. But I can see we can link everything including sexuality to spirituality. (UA-FG/31-53)

Another student, in the same group, contributed:

... the idea of spirituality has widened my perspective of looking a person as a whole - that each person is different individual...it helps me in appreciating people that it is not just about religion but more as a person in their life. (UA-FG/26-28)

No relevant data on existential aspects was reported by students from UB. However, Students from UC related the existential concepts of empowerment and autonomy to spirituality:

It may be related to activities of daily living, threatening or non-threatening issues. Depends on patients' needs and control, giving choices. (UC-FG/L1524-1525)

A student from the same University also recognised that spirituality was about more than religion:

It is about religion but everyone has sense of spirituality whether they are religious or not. It's not about physical needs, it's about... kind of self-respect, and how important life events are to them, so in a kind of broader sense. Not just about thinking what could be the practical things to do but how it may impact this person and how they see themselves. (UC-FG/1492-1496)

10.3.1.2 Connectedness

Some participants defined the concept of spirituality as involving (possibly metaphysical) connection.

As one lecturer put it:

Spirituality is a sense of our being and how we connect to the world. We do in Learning disability nursing, as it is so much about helping people. To understand that personhood and to be a part of society and to speak to very individual needs, advocate them, enabling people, to express themselves, I think its integral to spirituality. (UA-Int 01/L898-901)

Educators from UB did not mention the sense of connectedness. However, at UC in a statement that can be linked to the sense of connectedness, one nursing educator related spirituality, caring and being willing to just sit with somebody:

...I think it is saying too much of holistic care but people really need to think about what caring is all about. It is very strange but wonderful and civilised concept. It is easier to tick off for organic things than to sit with somebody... (UC-Int03-L2173-2175)

Students from UA related compassionate caring to spirituality:

We learn and practice 6Cs to provide person-centred care. Through compassionate care and therapeutic listening, we can provide spiritual care. (UA-FG/30-32)

Students from UB explained spirituality as source of connectedness in the widest sense:

It [spirituality] is about Connectedness. Connecting with someone. It could be meditation, beliefs, systems, personal, different things to different people. (UB-FG/L1365-1366)

One student from the same University shared an example from her clinical experience:

It could be very emotive; they would have lot to tell... life experiences. There was one patient and all he wanted to do was wanting to see his dog. So, we arranged to bring dog in ward. For me it was kind of connectedness. Before seeing his dog, he was isolated...after that he just almost like alive again. (UB-FG/L1374-1377)

Students from UC shared views similar to those of students from UA and UB on Compassionate care, as mentioned:

Being flexible and tailoring your care to their choice, probably is the best you are going to do. What can I do to help and I don't know to what extent they believe in such things, and I think it would be improper to assume of their background, lives etc. I just have to be listening and accommodating as much as I can. (UC-FG/L1553-1556)

Another student shared:

It is something we do as nurses, we are drawn to nursing, we connect to people, we do it often realising it how we relate spiritual care aspects. (UC-FG/L1535-1536)

10.3.1.3 Religious affiliation

Many participants saw religion and spirituality as distinct but overlapping concepts but some struggled with the distinction and others saw them as inseparable. Some responses, particularly in relation to death and dying, associated spirituality with beliefs about the after-life and the ritualistic aspect of religion.

An educator from UA defined religion as a structured way to approach spirituality:

Spirituality means many things and it depends on which context I am thinking and to whom I am talking. Because I could relate myself to God, I can easily relate it to religion. Sometimes it is easy to relate it with religion, because of the structure and construct within the religious doctrine. For me spirituality is life itself and how you connect with is the world outside the physical world and the things we don't know about, is very spiritual. (UA- Int02/1160-1166)

UB educators did not talk about religion and spirituality.

From UC, an educator who struggled with the distinction between religion and spirituality expressed particular concerns about care of dying people:

...if you speak to religious people they may not believe spirituality outside religion. However, I am not entirely convinced that people without strong religious background may take it as moral actions, not quite sure. I sometimes think no matter how you frame it, it is related in end of life course. If students know about religious needs of their patients, they may get a religious chaplain, imam, rabbi, whoever can deal with that, so that patients may feel satisfied about getting advising about their end of life... I think in some ways these aspects are source of anxieties such as, death issues, hell and heaven and how they will die. (UC-Int02/L 1975-1992)

Students at UA shared their clinical experiences of performing nursing assessment and asking patients about their religious affiliations to explore spiritual care need. They asserted that religious and spiritual care were sometimes assumed to be the same during nursing assessment:

In professional setting, spirituality is more religious based on the assessment part we do. From filling out the admission form, person's religious affiliation, tells you about what denomination they belong to and they will tell you Church of England or Roman Catholic. (UA-FG/38-40)

However, on personal level not every student agreed that religious needs could be seen as the same as spiritual care need.

From the first placement, I have realised that the common factor was that the older people are very religious and traditional based. They tend to be less accepting that religion and spirituality are different things...but to me these are different things. (UA-FG/L42-45)

A student from UB related spirituality as closely embedded concept in religion:

To me religion and spirituality is intertwined together. (UB-FG/L1409)

However, another student from the same university pointed out that spirituality was not confined to religious beliefs only:

You don't have to be religious to be spiritual. (UB-FG/L1465)

At UC, a variety of views were again presented by the students. One student strongly identified spirituality as related to religion and cultural practices:

It's about cultural belief like Sikh have 5 KS etc. (UC-FG/L1491)

Another student in the same group took a more nuanced approach:

It is about religion but everyone has [a] sense of spirituality whether they are religious or not. It's not about physical needs, it is about their...kind of self-respect and how important life events are to them. So, in a kind of broader sense... how it may impact this person and how they see themselves. (UC-FG/L1492-1496)

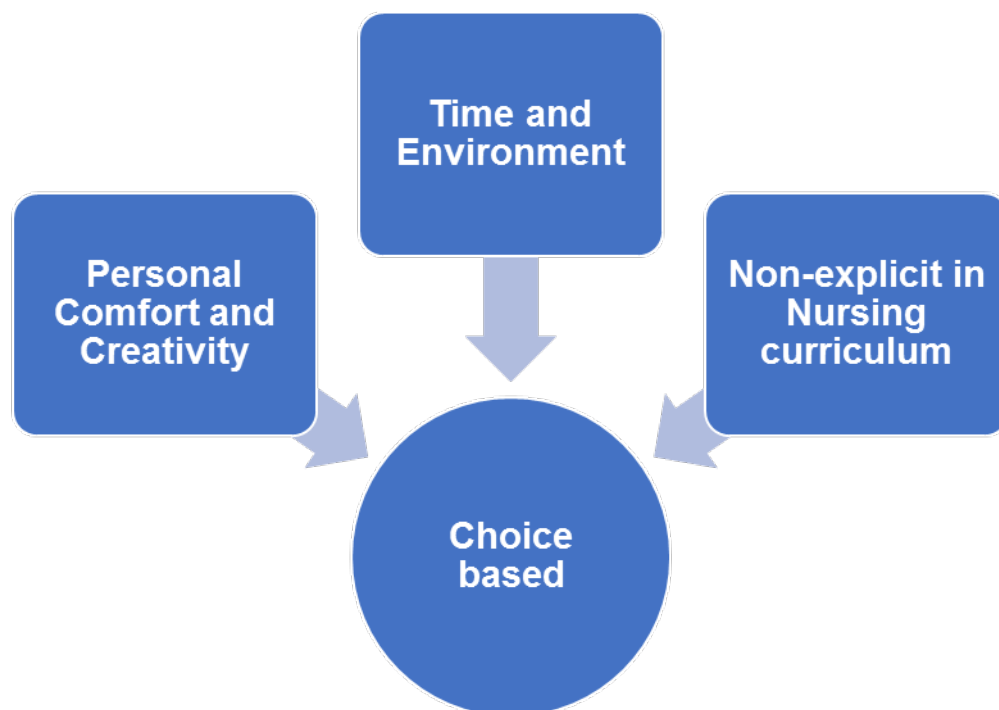
On a personal level, students had personal beliefs which might or might not relate religion to spirituality. However, in delivering nursing care, most students across all cases related the concept of spirituality to religious affiliation, which could be demonstrated simply by ticking a box on the assessment form.

10.3.2 Choice-based

The implementation of spiritual care and teaching was seen to be optional, based on personal choice. Various factors related to personal comfort and creativity, professional issues and the working environment were recognised by participants across all cases, arguably demonstrating that education

in spiritual care and its application were often regarded as optional, based on personal choice. These will be referred to in the sub-themes below. Figure 2 illustrates sub-themes.

Figure 2: Theme Two-Choice-based



10.3.2.1 Personal Comfort and Creativity

Data from educators and students revealed that teaching and learning about spiritual care was largely a matter of choice partly dependent on the educator's own interest and creativity. The extent to which spirituality was integrated into nursing education was strongly affected by individual interest and confidence level. There was a lack of clarity and some discomfort around how spirituality related to culture and religion. Spiritual care was also recognised, by some participants, as covering more than religion and rituals for a person.

The number of variables influencing professional preparation to deal with spiritual issues was highlighted by one nursing educator:

...teaching spirituality depends on who teaches and how it is taught. How students receive it and apply it to practice. (UA-Int03/L818-819)

As discussed in Chapter One, as a result of the NMC Code not being specific about spiritual assessment and care, it appears not to be required that nursing educators cover spirituality in their teaching. The educator at UA quoted above, referred to the earlier specification for nursing graduates (NMC, 2010) ... rather than the later Code (NMC, 2015). She affirmed that, although the NMC acknowledged the need to integrate spirituality in the nursing curriculum, at least as far as including spiritual needs in nursing assessment, how (and perhaps whether) it was done seemed to be a matter of choice.

Some nursing educators at UA asserted that, since spirituality was at the core of nursing philosophy, it was already implicit in all nursing theories, the care ethos and assessment criteria. Some thought this meant the 'label of spirituality' was not necessary in nursing education. One nursing educator said:

Spirituality is not explicit in the nursing curriculum. There are aspects of spiritual care. Examples like values-based nursing, importance of self-awareness, reflection and importance of recognising diverse backgrounds and respecting them, it's all about being person-centred...it is all about spirituality. (UA-Int 05/L311-314)

At UB, educators asserted they were following NMC guidelines and, since spirituality was not explicitly mentioned in the guidelines, fitting it into a packed curriculum was a matter of choice and personal creativity:

...because patient as a whole has to be looked at for everything in observation with NMC. There is so much you have to fit in to the curricula. (UB- Int 02/504-505)

At UC, educators incorporated spirituality in their teaching in relation to communication and end of life care:

I think if we have more clarity [on spiritual care], it will make people less anguish in terms of end life care. We obviously have sessions on communication, I don't think spirituality is addressed anywhere else, as far as I am aware. In second year when we do end of life [course], we do cover it. (UC-Int02/L1997-2000)

A student from UA considered that students also made choices based on their comfort level:

Some students they don't want holistic...holistic care is not for every practitioner. (UA-FG/L103).

Students from UA also recognised this difference as a difference in approach among different educators as,

Some tutors are different in a way they would approach it. I feel that way with them. so, you can tell with the lecturer, you can feel that openness or if it is not so. Some will not even refer spirituality to care at all. We are doing leadership now, but there is not spirituality, you have to mention it. So, if [it is] something you are not teaching or teaching how to approach it, students are not likely to apply it. (UA-FG/L145-149)

From UB a student mentioned about personal interest and educator's support at the clinical level in planning patient's care:

We do discuss what patient is feeling. Spirituality is to do with the state of mind and feelings. Our patient expressed his fear, we discussed that. Even at hand over. (UB-FG/L1429-1431)

Students at UC also saw spiritual care as a choice- based practice based on contextual issues and clinical priorities. As one student shared:

It is important to have an assessment on it [Spiritual need]. But these are unlikely that I am going to ask if the patient comes on A&E. (UC-FG/L1522-1523)

Views ranged from the idea that nurses could approach spirituality within the domain of person-centred care to the idea that spiritual care was just a synonym for religious affiliation. There were also diverse views about whether engaging with patients' spiritual care needs was a duty on nurses as part of their professional code of practice or whether this could be left, as a matter of choice, to individual nurses (or even specialist chaplains) based on their level of comfort and their own personal values and beliefs, regardless of professional accountability. The findings of this study therefore identified potential gaps in preparing nurses for professional accountability.

10.3.2.2 Time and Environment

Issues influencing spiritual care in nursing practice were also based on the demands made in particular areas of care which could effectively limit a nurse's options for providing spiritual care, for

example by simply not allowing them time to listen to a patient's deep concerns. Most of the participants mentioned that in acute care settings, nursing priority shifted to a so-called "medical model" rather than focusing on psycho-social integrated care and education also tended to focus on the acute model. Participants recognised such environmental pressures as barriers that influenced their decisions in structuring time and task based priorities over holistic care. Nursing educators also recognised that since there are no specific guidelines by NMC on how to integrate and address spiritual care in nursing education; this further complicated the situation for educators. As one educator shared:

...but still I think the standard for pre-registration is tighter and tighter, and things get lost. So, it makes it more difficult. (UA-Int 03/L844-845)

Another educator shared:

One of the things, I know we benefit in learning disability services is that we do have luxury of time. You might not get it for example in A&E, where you may have somebody coming in for hours. And so, only the skilled practitioners can make those connections with people very quickly. (UA-Int 01/L1026-1029)

Spiritual matters were reported as overlooked in nursing education and practice because nurses might feel they had done all that was needed in this domain by ticking the appropriate box for the patient's religion. As one nursing educator from UC said:

We teach all nursing models and theories and its applications at university but it depends on individual clinical placements and different hospital assessment tools, it tends to be tick box. There are tick boxes asking which religion are you. [A] Further question is not asked most of the time, because it is personal and it is not discussed openly like psychological wellbeing. Wellbeing is personal but people do talk about it but for religion people don't tend to go for those conversations. (UC-Int 04/L1747-1751)

Another educator emphasised upon the need for reduced paper work so that nurses could focus on person-centred care.

Empathy, listening, letting them being themselves, ultimate form of caring, not being tasks or goal orientated. We used to do therapeutic communication, but now everything is about doing ticks. Just need to be about giving people space, may be reducing paper work load. (UC-Int01/L2142-2145)

Students from UA also reported the, “*Tick box*” approach as a dominant way to provide care due to time and work load constraints.

In community, assessment is rather more detailed. But in clinical [acute care] we just have to do tick and sign our names. Nobody teaches you how to fill out forms and no details, it's just task based. (UA-FG/L194-195)

Students at UB also highlighted pressures sometimes generated by clinical emergencies. One recounted a harrowing account of how she had wanted to be present for a recently bereaved patient but had been called away because of an emergency elsewhere.

Every nurse you talk to, they are bombarded with paper work. One emergency takes you away from other patients. One day I walked in [a] room. She lost her brother. She took his photo and started talking and talking, but there was [an] emergency and I left the patient. I ignored it, like I shut her down. (UB-FG/L1437-1439)

A student in the same focus group also contrasted the situation in community nursing where there was more time for the patient with that on the acute ward:

Depends on environment. If you work in community its different. If you are working in acute care trust its different. (UB-FG/L1444)

During the focus group study at UC, students discussed the dynamic of disease-centred care over person- centred care due to time constraints:

I think there are things depending on the phase or areas bit of medical treatment, getting started until you identify a reason or cause to think about spirituality, other things in patient's life, their community social life etc. are there, but when they come in... there are other needs, primarily medical. (UC-FG/L 1514-1517)

Another student stressed the conflict between spiritual care and the traditional ‘medical model’ of acute care:

Spiritual care is an opposite and totally different from the traditional medical model. (UC-FG/L1594).

10.3.2.3 Non-explicit in Nursing curriculum

Current curriculum structures examined in this study appeared to rather gloss over the role of nurses in relation to spiritual care. As a separate section in this chapter, on Curriculum review discusses this further, based on the findings across all case studies. What was taught in practice was gleaned from interviews and focus groups. One educator from UA implied that, although spirituality was not always explicit in the nursing curriculum, it was implicit in certain conceptual areas such as person-centred care:

It's not explicit [in the curriculum]. There are aspects of this. Examples, like value based nursing, importance of that, self- awareness, reflection, importance of recognising diverse backgrounds, respecting, it's all about... and being person-centred is all about spirituality.

(UA- Int 05/L311-314)

Another educator from UA noted that discussion of spirituality was more likely to be found in particular clinical fields such as mental health, learning disability and palliative care and less likely to be found where the focus was more on specific illness:

It depends on the field of nursing. Mental health and learning disability are far more open to certain degree to relate spirituality with the exception in adults in palliative care. I do teach in four fields, first and third year, its different field in each speciality. But I know spirituality is been talked about when they say palliative care, mental health nursing and learning disability. When we talk social and holistic care and person as whole, we talk about it. But when we talk about specific illness, it is lost and not covered. (UA-Int 02/L 1142-1147)

At UB, the educators leading the undergraduate nursing programme however, could not identify how or whether spirituality was integrated in the nursing education:

I don't know. To be honest and it's really bad of me. I don't know, exactly how spirituality is actually covered within module, or how they (Educators) focus on it. I know they will be focusing on patient as whole and holistic care. But, I don't know how specifically they deliver it. Or when tutors mark assignments, what they might be looking at in relation to that. I don't know, how it's covered in modules. (UB-Int 01/568-572)

Another educator at UB said that spirituality was not included as a direct module but believed it would be completely integrated in the whole programme. When asked about spiritual care in teaching and clinical practice, she pointed to the role of the NMC in validating teaching outcomes:

NMC observation validates everything we do. Our faculty follow all the requirements those set by NMC- (UB-Int 01/L608).

An educator from UC was less certain about person-centred care providing opportunities for education about spiritual care, citing the complexity of working in multicultural and multi-faith societies and touching upon fears of 'getting it wrong' that are explored in the theme of authority.

There is person- centred care but nobody wants to use that word [Spirituality]; as they feel scared that it will look like religion and that you are imposing some dogma on people. There are things in RCN, but they are so many different worries and bullies..., even more difficult as more multicultural and multi-faith societies, it's perhaps easier in mono cultural and mono faith society, to be upfront about things. But we are bit worried for people complaining, people saying that somebody has bought their opinion or views to something. Whereas, it's just about almost, psychotherapy, its therapeutic communication, sitting with patients. (UC-Int01/2099-2107)

Another educator could not relate Spiritual care to NMC guidelines as said:

Does NMC talk about spirituality? I am trying to think. It is absolutely shameful. (UC-Int02/L2003-2004)

One student from UA reflected on how avoidance of aspects of spiritual care could lead to difficulties in putting whole-person care into practice:

I have been taught to look at clients as a whole but never been told that how to treat them as whole, it could be about religious belief but no other- wise, so we don't give our patients that appreciation as we were never taught! (UA-FG/L132-134)

The issue of the illness-focused (so-called) 'medical model' tending to displace spiritual approaches was reinforced by a student from UB:

In terms of the medical model, spirituality is found very low down, definitely. No specific or deliberate attempts, as an explicit element in nursing education. (UB-FG/L1456-1457)

When students from UC were asked about their care priorities one reported that in acute care, especially at A&E:

I don't think, so I need to get involved in these [spiritual care], it's a judgment I don't have to make. (UC-FG/L1529-1530)

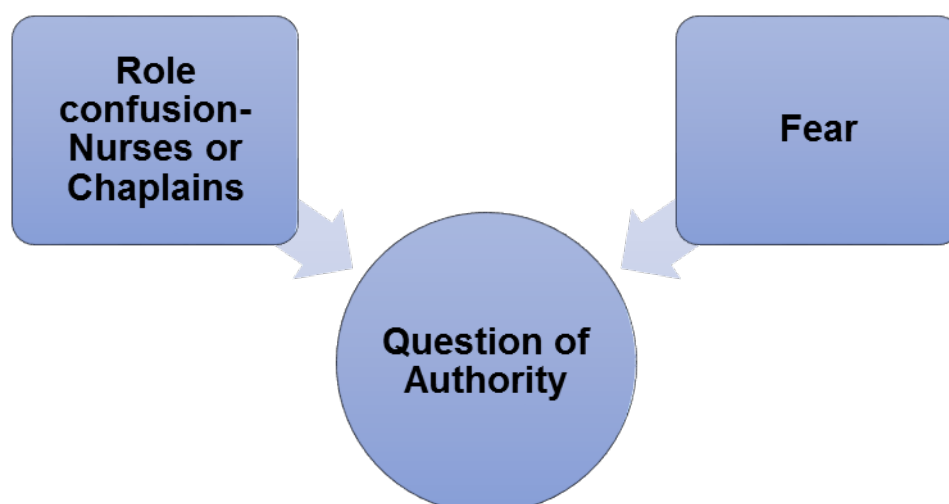
There was a perceived conflict between the disease-based “medical” model and the psycho-social “humanistic” model especially in acute care settings. Tick box based assessment criteria and lack of mention of spirituality in the NMC Code (2015), as well as issues in academic and practical teaching, gave rise to discomfort, insecurity and hesitant behaviours which resulted in avoidance of discussing spiritual issues in the classroom or clinical placements.

10.3.3 Question of Authority

Participants identified certain issues when asked about their competency and preparedness to approach spirituality. Areas of concern were not just about who had the knowledge and skills to engage in the spiritual area. There was also a question about authority and an underlying fear of “getting it wrong”, perhaps by being unintentionally insensitive about a patient’s own religious belief.

Figure 3 illustrates the sub-themes as follows:

Figure 3: Theme Three Question of Authority



10.3.3.1. Fear

One of the common concerns raised by both nursing educators and students was about the professional ethics of discussing “personal” matters like spirituality or religious belief. Often, spiritual care was associated with praying with patients and, since there was an underlying fear of breaching personal and professional boundaries, some participants preferred to avoid addressing spiritual issues at all. One nursing educator from UA asserted:

I think people think it is nothing to do with me, it's not for me and therefore I am unable to support somebody else, to participate in some sort of worship or discussion or may be and lot of different religions in UK. And I wonder people worry of getting it wrong and people [are] frightened of supporting any culture in an inappropriate way because perhaps they don't understand enough about it. (UA-Int 01/ L929-933)

No data relating to fear was mentioned by educators at UB, as mentioned in Chapter Six.

An educator in UC expressed personal conflict about their own faith background and implicitly about talking about spiritual matters just because spirituality was so subjective:

I personally feel very conflicted about it; I am being very honest. My personal background is as a Christian, but if you have liberal and you may have your own understanding and its very subjective belief. I don't feel that authority, feel very uncomfortable talking about these [things]. (UC-Int 02/L1959-1962)

The same interviewee, when discussing the distinction between religion and spirituality said:

I struggle [with] that distinction little bit and I think in some ways there are source of anxieties there. Death issues, hell and heaven and how they will die. They are more general rather what my life is for...we teach them listening etc. (UC-Int02/L1991-1994)

A student at the UA, who came from a culture where spirituality and religion were part of daily life found the optional and private nature of religion in the UK a challenge:

I am coming from a different environment [where] spirituality and religion was there from school level as you grow up. But here, when I came to this country, these concepts are like optional or we never talk about. People are given choices and you cannot impose your values on some body... more cultural forces, many things have been evolved, something that really troubles me from my personal level. (UA-FG/L116-124)

One student from UB shared her confusion as:

Saying wrong things to them, worried about saying wrong things. What you mean by? umm, you make suggestions what they want to hear. If they are seriously ill, and you ask them to see religious person, they may think, oh I am dying therefore you are asking me. Even if I am not thinking about dying but it's nurse giving impression. (UB-FG/L1403-1406)

A student from UC felt that ideally the religious beliefs of nurse and patient should be congruent otherwise it could lead to confusion and the nurse might appear to be disrespecting the patient's beliefs:

It differs from patient to patient and nurse to nurse. If nurse is Catholic and patient is non-Christian or if it's me I won't go praying with a patient; it's not me saying no to that example of bad nursing but I will arrange someone else. A, I don't believe in it so it is not being honest. B, I don't feel comfortable being part of that ritual, so I don't have any concept of that, so it's like dishonesty and it will be more meaning full if both of us could actually carry same belief. ...I don't know what to do in such a situation. (UC-FG/L1540-1545)

These excerpts from both educators and students reflected that in a multicultural society, using the word spirituality was often perceived to present a threat to respecting the patient's personal autonomy. Since, there was an underlying fear of being misunderstood, spiritual care was sometimes avoided both in education and practice. Whether or not patients and nurses share religion and related beliefs, nursing philosophy suggests we should extend support and care beyond ethnicity and religious affiliation. However, owing to lack of explicit guidance in nursing education on how to approach patients for spiritual care, spiritual care was often overlooked.

10.3.3.2 Role confusion: Nurses or chaplains

Spiritual care was sometimes considered to be either a non-nursing domain or related to death and dying rituals only:

The formal assessments, when you assess somebody's mental wellbeing, nothing specific is asked. They will say what's your personal spiritual needs, but generally it is with reference to religious needs, pastoral needs, or prayer. It is limited if somebody wants to go beyond that. (UA-Int 02/L1181-1184)

No data was reported from UB educators on this sub-theme.

Several educators from UC emphasised the role and scope of chaplaincy care in relating spirituality to nursing education. One educator mentioned:

We have chaplains who are good communicators and teachers so they feel more competent talking about these sorts of issues. I feel I don't know the answers... there are people who are happy to talk about it and they should be encouraged to bring it forward. I also feel that it's my right not to talk about it, because it is painful. (UC-int02/L2025-2033)

Another educator from UC highlighted the issue of role ambiguity between nursing and chaplaincy care as an expression of knowledge and practice deficiency in nursing education.

... huge need for research across the whole health care and then how you put in health system. It is nebulous so how would you objectify that is very difficult. People denied of spiritual care, because it is not addressed at all. And practically it is not possible from religious perspective, especially if you are in hospital. You could have one chaplain, or one imam and people are dying every minute, so again you need a team...and how nurses be prepared to deliver care in spiritual way... But there are lot of questions unexamined from practice point of view as well, both from education gaps as well, huge number of gaps. (UC-Int04/1754-1764)

A student at UA struggled with the concept of spirituality and its scope in practice in nursing. The student generally related spirituality with religion and as a domain under chaplaincy services. Hence could not relate nursing role to provide spirituality competent care. As mentioned:

... the whole terminology requires defining, as this is tricking us. What is spirituality?... that causes problems. (UA-Int 06/293-294)

One student at UB related spiritual care with end of life care and defined the role of nursing students in arranging chaplain visits, only. Spiritual care was conceived in a very restricted term of advocating and arranging referrals only.

If the patient is unstable then chaplain visits are helpful. (UB-FG/L1396)

In another focus group at UC, the role of chaplains was said to be more appropriate in providing palliative and end of life care through pastoral support.

We have chaplains, so if a patient with a terminal condition needs support, we arrange chaplains. Or if emotional support is required. Person-centred care etc, we would definitely try to be flexible and see what the patient wants, rather [than] what I do. But then you need to

have time to talk through these things in length...in the morning, it's quite rigid, you got your wash or you did [not] get your wash. (UC-FG/L1501-1505)

Since the “luxury” of time was identified as an important factor in providing emotional support and caring presence to patients, some students preferred referring patients to chaplains for spiritual care. They were also not sure that they, as nurses, could or should be involved in existential care issues. Hence, referring patients to chaplaincy care was an easier and safer option, to avoid potential ethical dilemmas.

I don't think so I need to get involved in existential and spiritual care giving while providing acute care, it's a judgment I don't have to make. (UC-FG/L1529)

Chaplains were also seen as a resource for teaching spiritual care to nurses, especially at UC:

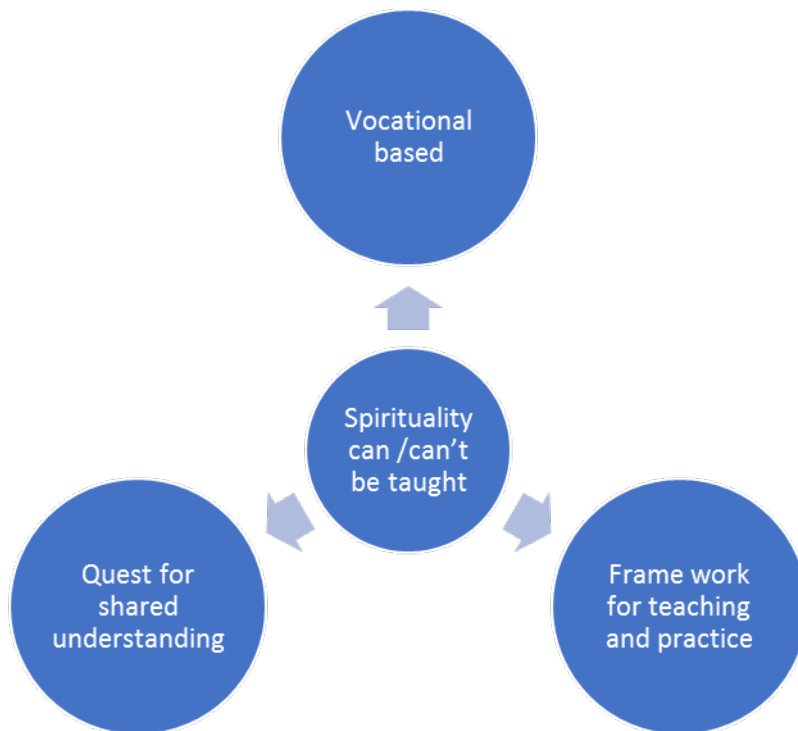
We teach it [spirituality] very broadly and not equating it with organised religion. One of the chaplains is invited as well for a two and half [hour] session to discuss spiritual care needs of patients. (UC-int02/L1954-1956)

Since specialised services including social workers, psychotherapists, and chaplains were accessible, based on the choices and needs of patients, some students believed that the spiritual care domain was not directly related to nursing care. Some students declared that spirituality had a limited place in nursing education as providing person-centred care was “common sense” and no special attention was required.

10.3.4 Spirituality can/ can't be taught

Through this study, participants were encouraged to discuss whether spirituality could and should be taught in nursing education? Since spirituality was considered to be a very personal and sensitive issue, it was important to explore how to approach spirituality in nursing education, when there were underlying fears and role ambiguity associated with the term spirituality. Participants acknowledged the difficulties and challenges and sought to develop some shared understanding and empowerment through more dialogue, self-exploration and learning support both for educators and students. This is further discussed as sub-themes below. Figure 4 illustrates the sub-themes as follows:

Figure 4: Theme Four-Spirituality Can/Can't be taught



10.3.4.1 Vocational based:

Approaches to spiritual care appear to be highly based on the individual personalities and life experiences of both educators and students.

Some asserted that since nurses are trained for “clinical” expertise, spiritual care was a non-nursing domain for which chaplaincy services should be provided. Especially, in a multicultural society, after knowing the religious affinity and referring the patient to specific faith-based services maybe a nurse had fulfilled her role:

...in one sense, it is shame and we could do more...it's a really sensitive and complex area. Because within the culture of our health systems and education system spirituality is not something highly talked about, it is very much seen as a private issue. What I think in last forty years, all things related to religion and spirituality have become very personal and atomised. (UA-Int04/L464-473)

Educators from UB also emphasised a therapeutic role for nursing educators in empowering student nurses and facilitating spiritual development:

My role is to find out the best way of meeting needs required from NMC without transferring my own opinion to students, so that they can enjoy the experience...they can really learn to look after themselves, learn through stressors, hardships, up and downs, learning to negotiate when things are not their own ways. Also, learning through new experience, from new areas, and then taking on new practice, and sharing with people. (UB-Int 02/L655-657,663-666)

According to some participants teaching spirituality involved recognising cultural values and belief systems as part of psycho-social care models but to others it was a specialised area covering aspects of holistic care through various curriculum strands:

So, in the sense of holism what I teach, I definitely bring in holism perspectives. Students actually ask and assess for spiritual needs. Spirituality and religion, I found very different themes...especially in contemporary world, where people are actually involved in secular sciences and actually grabbing pieces, what suits them. (UC-Int 04/L1671-1674)

Nevertheless, not many participants were in favour of having a formal course focusing on spirituality. Virtually all agreed that there was a need to explore more about spirituality and its scope in nursing. One student during the focus group at UA expressed the importance of the individual nurse's personality and, perhaps resistance to learning in this area:

There is no way to drill them in someone's mind, they will treat their patient the way they want to treat their patient. (UA/FG-L94-95)

A student from UB expressed similar thoughts about the centrality of the 'being' of the nurse, learned from experience rather than textbooks:

You need to have skill of adaptability. It's the personality of the nurse. The book can tell you much about theory, but experiences make you learn. (UB-FG/1419)

This was further affirmed by a student from UC:

Spiritual care is not academic, it's all experiential. (UC-FG/1598)

Through this study, it was reported that the concept of spirituality was very broad and based on ontological, vocational and interpersonal factors. It demanded a different pedagogical approach to the knowledge required for traditional evidence-based practice. Spiritual competency could not be taught or drilled through formal class room teaching or standard clinical competency building techniques.

Acquiring spiritual competency was, at least in part a developmental issue of 'becoming' rather than simply acquiring knowledge. It was not easy to assess or measure spiritual care on empirical grounds in formal evaluation of outcomes in nurse training.

10.3.4.2 Quest for developing shared understanding

Both nursing educators and nursing students identified a need to develop a shared understanding of their own spirituality and the spiritual care needs of patients. They thought that recognising personal fears and anxieties and spiritual needs as well as understanding cultural issues might be a prerequisite for assessing and dealing with the needs of patients:

I think people think it is nothing to do with me, it's not for me and therefore I am unable to support somebody else, to participate in some sort of worship or discussion or may be and lot of different religions in UK. And I wonder people worry of getting it wrong and people [are] frightened of supporting any culture in an inappropriate way because perhaps they don't understand enough about it. (UA-Int 01/ L929-933)

One educator from UB, whilst acknowledging the need to integrate spirituality into training, suggested online training and modules through e learning to develop competency in spiritual care.

We need spirituality to be integrated in teaching and training...,could be introduced in e learning. (UB-FG/L1399)

To develop more awareness and debate around personal fears and anxieties on spirituality and spiritual care, some participants suggested an e-learning mode that could be flexible in terms of time and accessibility of content. However, others saw potential drawbacks in using these learning methods too:

...some [students] will engage and some will not, ..., it has an area of potential for making learning valuable by sharing ideas; otherwise we would be learning what is given and not exploring and I think that is the essence of spirituality. It's exploration of self and of others and its integration of self and others. Through virtual media, we run a risk of isolation. (UC-int03/L1938-1945)

Some participants emphasised that by developing more reflexivity about resilience and effective coping, burn out, self-exploration and passion to care, both nursing educators and students could embrace spirituality in its widest meaning and find more confidence in articulating it in practical care:

...it is very important to explore a student's own spirituality, as sometimes it is only for patients but not for students as such. If you don't know it by yourself how to expect it for others. You find yourself and transform yourself and come in to it more ... by having more empowerment. (UA-FG/L166-169,172)

Students from UB emphasised that educators should prepare students how to understand and address spiritual care needs of their patients:

They (nursing educators) should teach us how to ask questions and how to be aware of spiritual care need. Because you can't teach what is it. Because it's different for everyone. (UB-FG/L1468-69)

Students from in all cases reported the same quest for developing empowerment to address spiritual care needs especially during clinical attachments. Students identified the need for more support from nursing educators to develop their competencies in this area. One student from UC stressed the importance of spirituality but also the difficulties in addressing it:

I think spirituality is very necessary and it forms patient's choice. How people choose to take health care and what is being healthy for them. But it is time to apply on each patient, large assessments on each patient, it is very very difficult. (UC-FG/L1519-1521)

More discussion and research were recommended to develop dialogue among educators and students to promote confidence and clarity on spiritual care.

10.3.4.3 Framework for teaching and practice:

This sub-theme concerned the need for a framework for teachers, based on a shared understanding of, how to address spiritual care in nursing education and where spirituality was located in relation to related issues like holistic and compassionate care. A nursing educator in UA identified the need to increase the emphasis on spirituality as an aspect of holistic care:

Spirituality is an aspect of holism but it is not given the same emphasis, emphasis is, tends to be, on psychosocial, biological elements and spirituality sometimes lumped in psychological aspects. (UA-Int02/1155-1157)

An educator from UB also emphasised developing more specific teaching and learning approaches focusing upon person-centred care:

There is an element I would take out from curriculum, to make room perhaps [for] more person-centred journeys. I would like to see more person-centred journeys, but I know the reality is we have got a lot of student nurses, now from all backgrounds, ... I think each field in nursing is now becoming more generic and that I don't think is helping..., it's far too generic.

(UB-Int 01/633-641)

An interviewee at UC specifically mentioned the need for a teaching framework that could be a guiding tool for educators to integrate spirituality as an essential aspect of nursing education:

There is not competency out there on performing spiritual care assessments, there are RCN guidelines on spirituality in lines with dignity and respect, but there is no framework out there for actually how you teach students. Spirituality is part of nursing assessment but mostly nurses find it difficult and as an alien concept. I did my Masters 10 years ago, and looked for any frameworks to teach or assess on spiritual care needs but they weren't there, particularly in a multicultural society in London, most diverse community in world possibly, but there is not a framework. (UC-Int 04/L1696-1701)

10.3.5 Curriculum Review

Curriculum documents were reviewed from each case study, to explore whether and how spiritual issues were covered.

A detailed discussion on findings from UA, UB and UC on curriculum review is provided in the chapters that deal with the three main case studies (Chapters Five, Six and Seven).

A modular representation of each course with theme specification where spirituality is mentioned both implicitly and explicitly, has been presented in Table 13: Chapter Five, Table 14: Chapter Six and in Table 15: Chapter Seven, as single case studies. However, no knowledge or skill based assessment criteria were used at UA, UB or UC to assess competencies required to understand and address spiritual care needs.

In UA and UC, spirituality was recognised as a sub-theme; to be covered in various modules.

However, no descriptive details or module outlines were found specifying how spirituality should be

approached. Integrating spirituality seemed to be a matter of choice for the nursing educators, to plan their teaching around the given theme. As an educator from UA said:

There is more in terms of compassion, as it is one of the 6Cs and been taught and that element is assessed by essay, by understanding and application of 6Cs. Clinical portfolio and ticking, working with mentor, it has the element of it. These are individual strategies but no way of formalising the course and evaluating when they left. (UA-Int 02/L1325-1331)

Educators from UC describing the curriculum structure highlighted the issue of choice-based integration of spirituality in nursing education:

We have module descriptors, which give the outline of the basic component[s] of the module, there are competency headings. No descriptions; it's more how you adopt to do it yourself, ensuring that spirituality is intrinsic to a thought and how you apply that and I am sure in more Universities it is more descriptors rather [than a] more definitive way. That probably would not be right; it may lead to variances in how it is delivered. (UC-Int03/L1869-1874)

For UB, due to the flexible nature of the learning institution, no specific curriculum documents were developed to outline any course themes. Only major courses as per the progression requirement from NMC were identified. Because of the teaching and learning structures in UB, the nursing programme lead facilitators were unaware about how, if at all, spiritual care was integrated in nursing education. One educator said:

I don't know. To be honest and its really bad of me. I don't know, exactly how spirituality is actually covered within module, or how they (Educators) focus on it. I know they will be focusing on patient as whole and holistic care. But, I don't know how specifically they deliver it. Or when tutors mark assignments, what they might be looking at in relation to that. I don't know, how it's covered in modules. (UB-Int 01/568-572)

Nursing educators at UB did not know whether spiritual care aspects were explicitly addressed and discussed by other educators or clinical tutors. However, the educators assumed that, considering NMC expectations, students were adequately prepared to deliver holistic, person-centred and compassionate care but uncertain as to how spirituality was covered.

10.4 Summary

Participants shared their personal experiences in defining and integrating spirituality with nursing education and practice. There was a variety of existential, humanistic and religious approaches. Spirituality was related to meaning in life, hope, compassion, connection and a belief system by the participants. Due to personal beliefs and value systems, participants expressed their fears and anxieties in relating to aspects of spiritual care. Spirituality was a very broad and abstract concept. Some participants identified it as especially appropriate to palliative and end of life care and associated religious death and dying rituals. Others related it more broadly to compassionate care. Most participants associated spirituality with existential aspects and with a humanistic ethos. In general, spirituality was identified as an implicit concept in nursing courses. However, curriculum review from each case revealed that there were some issues in relating to NMC guidelines and developing testable competency standards. Since, there was no standard curriculum structure for the undergraduate nursing programme, each case chose its own approach to spirituality.

Research participants recognised the need to develop a shared understanding among clinicians, educators and students to recognise spiritual care as a core part of nursing care. Some of the participants emphasised the need for a clear and practical framework to integrate spirituality in nursing education. Because of time and work load pressure in the acute care environment, spiritual care could be compromised. Other participants, particularly from UC where chaplains were involved in nurse training especially around palliative care, related spiritual care to chaplaincy services. There was doubt about how far spiritual care was a role for the nurse and how far it should be left to the specialist chaplain. Some participants believed that since it was an abstract concept, addressing spirituality was (and perhaps should be) left to individual educator and nurse choice and personal creativity.

Chapter Eleven: Discussion

11.1 Introduction

This chapter discusses the research findings in the light of the study aims and case study propositions. It integrates the study findings with the literature review (Chapter Two). Also, it introduces new literature on nursing education, the relevance of which became evident as data were analysed. Based on a critical data analysis, this chapter seeks to recognise the underlying curricular and non-curricular pressures influencing the integration of spirituality in nursing education over the last few decades. This chapter highlights key findings and proposes some ways forward in developing this area of nursing education. This includes suggestions about further research and a teaching and learning framework which attempts to integrate the findings. This framework stresses the importance of self-exploration and ontological development in *becoming* a nurse competent to address the lived experience of spirituality in a compassionate and empathetic way. It has been given the acronym SOPHIE which will be explained in full later in the chapter. Alongside the findings about current issues in addressing spirituality in nursing education, SOPHIE encapsulates the main issues the researcher believes need to be addressed to establish clarity and an explicit representation of how spiritual care can be approached in nursing education. A chapter summary is provided at the end of the chapter.

11.2 Research aim and findings

As discussed in Chapter One, this study aimed to contribute to a better understanding of how nursing competencies in understanding and addressing spiritual needs are currently approached in undergraduate nurse education.

The research objectives set for this study were:

1. To examine the course curriculum and related documents for undergraduate nurse education in different schools of nursing, across England.
2. To determine the views of key nurse educators in those schools about how teaching on spiritual care is delivered and how it might be improved.
3. To determine how teaching on spiritual care is perceived by students in those schools across England and how they think it might be improved.

4. To understand and synthesise these findings in a way that might contribute to developing education in this area further.

11.2.1 Case study Design

In accordance with the multiple case study design to establish reliability and validity of the research findings, the data gathered based on literature review in Chapter Two were linked with the initial case study propositions for this study in Chapter Three. (Yin, 2009, 2014).

Data gathered based on the cross-case synthesis in Chapter Ten is further linked with the case study propositions and the literature review in the sections below (Yin 2009; 2014). As discussed in Chapter Three (3.2.4, 3.2.5) linking the data with the case study propositions, literature review and data triangulation based on cross-case synthesis, helps establish the chain of evidence to assure the quality and rigour of this study (Yin, 2009, 2014; Robson & McCartan, 2016).

11.2.1.1 Linking the data

Following is a brief overview on how propositions, literature review and findings from this research complement each other. The themes and sub-themes that emerged as findings from thematic analysis of the research data are then used as a framework for a more detailed discussion in section 11.3 linked to the propositions and literature review.

Proposition 1

There are conceptual barriers and gaps in relating spirituality in nursing education, due to which spiritual care aspects are currently neglected in nursing training and practice.

Findings from Literature review:

Students reported lack of confidence in their competency and felt they had not been properly prepared by their educators to address this area. Also, students recognised the need to explore their own spirituality before learning to approach others (Lopez et al., 2014; Ross et al., 2014; Kalkim et al., 2016). Bush (1999) proposed journaling as an effective self-reflection tool to teach the concept of spirituality. An informal Likert scale questionnaire was used to assess students' learning through journal writing, at the beginning and end of the study. The study found that students showed keen

interest in learning more about spirituality but expressed confusion about the term spirituality and its relationship to nursing care. A need for developing a formal teaching framework for nursing educators was highlighted by the study. Barss (2012 b), also identified some barriers faced by nursing educators such as; no explicit recognition of spiritual care, insufficient time, prioritisation of disease over person-centred needs, and role ambiguity of both students and educators when offering spiritual care. Using quantitative tools, six universities in four European countries (Wales, Malta, Netherlands, and Norway) were investigated by Ross, et al. (2014). Students were generally reported to be competent to approach spirituality based on personal beliefs. However, lack of competency in performing nursing assessment and planning care was identified. Similar issues were also reported by Yuan & Porr (2014) and Lewinson et al., (2015). A detailed description and critical analysis on each study is provided in Chapter Two.

Findings from the research study:

The research findings supported this proposition. Data gathered from UA, UB and UC (Chapter Ten, 10.2), showed conceptual difficulties in understanding and addressing spiritual care needs. Both nursing educators and student nurses shared their personal views about spirituality from a variety of perspectives including existential aspects, a sense of connectedness and with reference to religious affiliation. A few participants were reluctant to see addressing spirituality as part of the nursing role and saw spiritual care as purely a matter for chaplains. However, most participants saw spirituality as an existential resource that could give meaning, hope and inner strength to those facing difficulties in life. Participants related spirituality in nursing education to compassionate caring, existential advocacy and therapeutic listening. Based on personal experiences and beliefs, for some participants, addressing spirituality in a multicultural teaching and practice environment was a source of fear and anxiety (Chapter Ten, 10.3.3.1). Both nursing educators and student nurses emphasised the need to have more clarity and shared understanding about how to address spirituality in nursing education with more confidence and competency. Chapter Ten explored the findings from the cross-case synthesis in more detail.

Proposition 2

Student nurses recognise the need for adequate support from educators to develop confidence and competency in approaching spiritual care aspects.

Findings from Literature review:

Chapter Two recognised that due to environmental constraints, lack of clarity in the curriculum, and based on educators' personal choices, spirituality was often overlooked in teaching and learning practices. (McSherry & Draper, 1997; Timmins & Neill, 2013; Kalkim et al., 2016; Caldeira et al., 2016).

McSherry and Draper (1997) identified time, environment, financial constraints and work load as the influencing factors that became a barrier for educators in relating spiritual care aspect in nursing education. Kalkim et al. (2016) inquired about student nurses' perspectives on spirituality and spiritual care at a nursing school in Turkey which also revealed similar issues of time constraints, pressure of clinical priorities and lack of clarity from nursing educators on how to relate spiritual care aspects. Several other studies conducted on Asian nursing students also identified inadequate guidance and support in addressing spiritual care needs. (Tiew & Drury, 2012; Cooper, Chang, Sheehan & Johnson, 2013; Lopez et al., 2014).

Findings from the research study:

The research findings partly supported this proposition and associated findings based on the literature review. Participants from all three case studies identified environmental influences with reference to time, clinical priorities, teaching tasks and professional work load on both student nurses and educators. Because of these, spirituality was not considered to be a priority to integrate as an explicit aspect of teaching and practice. A more generalised (humanistic) psycho-social approach focusing upon person-centred and holistic care was identified as an antidote to the so-called medical model and a focus solely on the technical aspects of care. This is supported by findings in the medical literature (Wattis & Curran, 2016). However, based on educators' personal choices and competencies UA and UC reported a specialised teaching focus on spirituality. The approach taken by UA in year one and three by an expert nursing educator is discussed in Chapter Five (5.2). A specialised focus on chaplaincy care to integrate spirituality in nursing education was found at UC (Chapter Seven, 7.2). From students' perspectives across all cases it was again seen as a matter of personal choice of educators and students to decide if, and to what extent, they wanted to integrate spirituality into

education and practice. Since, in UC spirituality was strongly related to chaplaincy care and was seen as a choice-based practice, not all student nurses wanted to develop competency in this area. For some students' spirituality was seen as part of a vocational ontological approach to *being* a nurse that required a developmental approach to teaching (e.g. through mentoring). Nevertheless, all students emphasised that more discussions and shared understanding among professionals could be helpful to facilitate person-centred spiritual care (Chapter Ten, 10.2.4.2).

Proposition 3

Nursing educators lack confidence and training in this area. Views and concerns from nursing educators on integrating spirituality in nursing education are under investigated.

Findings from Literature review:

As discussed in Chapter Two, the competencies and support that nursing educators need to prepare nurses to identify and respond to spiritual care needs are little explored (Caldeira et al., 2016). Cone and Giske (2012), used grounded theory and proposed how to teach spiritual care by conducting a study of nursing educators. The grounded theory findings emphasised the students' need to learn spiritual care through *maturation* facilitated by role modelling in clinical care. Strand et al., (2016) studied a Norwegian university college students' response when mentorship to practice spiritual care was provided in a church-affiliated hospital ward. The study established that such partnership initiative and clinical mentorship, enhanced students' understanding and competency in approaching patients in clinical areas.

Findings from this research study:

Findings from this research study revealed some additional aspects about institutional characteristics that, influenced nursing educators' choices about integrating spirituality in nursing education. Every case presented a different approach and the teaching offered by the nursing educators was based on their personal expertise and orientation. UA had a spirituality interest group with multidisciplinary staff and nursing educators with a special interest in spirituality who were directly involved in sessional teaching in the undergraduate nursing programme (Chapter Five, 5.3). In UB, due to the flexible mode of learning structures, nursing educators could not provide relevant data on the competency level and

challenges faced in teaching spirituality, as discussed in Chapter Six (6.3). Spirituality appeared to be subsumed implicitly as part of holistic care. UC had a special interest and specialisation in chaplaincy care, which was reflected through their teaching and learning approaches, as explained in Chapter Seven (7.3). However, educators across all three case studies emphasised the need for more clarity and shared understanding to develop competency more generally amongst educators. Educators in all three cases endorsed the need for more research, discussions, mentorship and a clear teaching framework to improve systematic integration of spirituality in nursing education (Chapter Ten, 10.3.4.3). Such interventions would enable self-exploration among educators about their own spiritual needs as well as facilitating them to prepare confident student nurses to understand and address spiritual aspects of care.

Proposition 4

The nursing curriculum does not explicitly integrate spiritual care into nursing knowledge and practice.

Findings from Literature review:

Nursing students in a variety of studies reported inadequate teaching about addressing spiritual care in practice, insufficient mentorship by nursing educators and inadequate emphasis on spirituality and spiritual care needs within the nursing curriculum (Narayanasamy, 1993; Callister et al., 2004; Yilmaz & Gurler, 2014; Timmins et al., 2014; Ross et al., 2014; Kalkim et al., 2016; Spadoni & Sevean, 2016).

Callister et al., (2004) conducted a survey study in the United States of America, and identified that the concept of spirituality is inadequately articulated in nursing courses. Kenny & Ashley (2005) recognised the need for a specialised curriculum addressing spiritual care needs of children and their families. This study was further complemented by Murphy et al., (2015) who, asserted that children's spirituality development needs were not the same as an adult's spiritual care needs. Hence, undergraduate nursing curriculum and teaching practices should be revised. Timmins et al., (2014), studied core nursing text books (n= 580), and recommended that nursing texts should provide a consistent focus on spirituality by including spiritual care themes. Also, Yilmaz and Gurler (2014), established the efficacy of a revised and multidisciplinary undergraduate curriculum compared with a traditional nursing curriculum in Turkey. Caldeira et al., (2016) performed a cross-sectional descriptive

study in Portugal and Brazil. One hundred and twenty-nine email responses from nursing educators identified the need for a standardised undergraduate nursing curriculum.

Findings from this research study:

As discussed in Chapter Ten (10.3.2.3), research findings supported proposition 4 and the findings from the literature review A modular approach to the curriculum was found at two out of three of the case studies (Chapter Ten, 10.3.5). Only UA and UC had documents as course grids on the undergraduate nursing curriculum specifying units with potential themes to be covered as modules. No detailed guidelines were provided on how spirituality should be related within the course theme, as an essential teaching component of class room teaching. It was an open choice for nursing educators to choose and decide how individual themes were to be approached and related with the core nursing unit. On Curriculum review, there was no standardised guide or framework for nursing educators on delivering courses that could enable students to meet the essential professional requirements. With reference to spirituality both nursing educators and student nurses acknowledged that it was often a matter of choice, based on personal comfort levels. UB had no detailed curriculum document or separate course grids for any modules. There just appeared to be an assumption that spiritual matters would be dealt with under the rubric of holistic care and there was some evidence that this was occurring in the mentorship element of clinical attachments. In UA and UC, the role of mentorship, was well recognised. However, it was a matter of personal choice depending on the level of comfort and expertise of nursing educators to decide, whether, to what extent and how they wanted to address spiritual care in teaching and practice.

11.3 Discussion on findings:

In the following section, the research findings are discussed according to the themes and sub-themes identified in the study.

11.3.1 Conceptual complexity

During the study, participants expressed confusion due to the conceptual complexity surrounding the term spirituality. Spirituality was perceived as, *“a difficult concept for people and has different meanings to different people as well”* (UC-Int 03/L1792-1793). The multi-faceted aspects of the

concept of spirituality were defined in several ways in this research (Chapter Ten, 10.3.1), as recognised by McSherry and Cash (2004), Cockell & McSherry (2012), Narayanasamy (2014) and Caldeira et al., (2016). As a concept related to existential and humanistic aspects of life, spirituality was approached through concepts such as the sense of autonomy, self-awareness, self-reflection, actualising one's inner potential, identity, mindfulness, person-centred care, resilience and compassion. For some participants, the concept of spirituality within a religious understanding, was associated with death and dying, belief in the supernatural, God, heaven, hell and fear. Hence, it was reported that, "*people worry of getting it wrong and people [are] frightened of supporting any culture in an inappropriate way because perhaps they don't understand enough about it* (UA-Int 01/ L929-933). Figure 05 in Chapter Ten presents a summary of different perspectives on how participants approached the concept of spirituality. Failure to recognise the various concepts embedded within the meanings and connotations of the term *spirituality*, including the fact that spirituality was not synonymous with religion, led to confusion associated with role ambiguity in nurses (Chapter Ten, 10.3.3). This reinforced and was, in turn, reinforced by disease- centred care.

The following are the sub-themes identified within the major theme of conceptual complexity.

11.3.1.1 Existential aspects

Spirituality could be approached as a journey to self-actualising the authentic self and transcendence. It has been characterised in the literature as being about, identity, meaning-making, purpose in life, truth, and values (DeCarvalho, 2000; Cook 2004; Caldeira et al., 2016). During the study, it was identified that for some participants, spirituality was an ultimate source of meaning and hope in life during crisis situations regardless of their religious affiliation or adherence to any particular belief system (Chapter Ten, 10. 3.1.1). Hence, the nursing role was recognised to, "*encourage the clients to be who they want to be really, and look for the way*" (UA-Int 06/L207-212). However, "*because [of] those existential questions like meaning in life*" (UC-Int 04/L1690); the concept of spirituality was found to be very complex. Both literature review (McSherry and Cash, 2004; Cockell & McSherry, 2012; Narayanasamy, 2014; Caldeira et al., 2016) and data analysis affirmed this. The literature review highlighted that there are conceptual, philosophical, cultural, political, linguistic and epistemological challenges in understanding and relating spirituality in nursing practice (McSherry &

Draper, 1997; McSherry & Cash, 2004; Cockell & McSherry, 2012). Spirituality (like “mind”) is an abstract concept. Koenig (2007, p 38-40) argued that many modern definitions were too abstract and indistinguishable from concepts in positive psychology to be used in research though he acknowledged that such broad definitions were useful in clinical practice. This complexity means that spiritual and existential aspects often remain unacknowledged in a caring discourse (White, 2000; Wattis et al., 2017).

11.3.1.2 Connectedness

Greenstreet (1999), Baldacchino (2008), and Nardi, et al. (2011), explored the concept of connectedness with reference to spirituality by acknowledging psycho-social and metaphysical aspects of human life. Hoover (2002), developed a course to emphasise and nurture transpersonal connectedness by care giving practices. During the study participants identified personal values like empathy and compassion that were driven by a sense of connection. Chapter Ten (10.3.1.2), on cross-case synthesis explored the concept of connectedness, as found in this study, in detail. This sense of connectedness through, “*compassionate care and therapeutic listening*” (UA-FG/30-32), allowed the participants to be more engaged and understanding towards others’ spiritual care need. This research confirmed that spirituality was in part about emotional availability and empathising with others’ need. Providing authentic presence and sensitivity to others’ pain and wellbeing through compassion were seen to be some ways through which spiritual care could be provided. Hence, nursing education should prepare students to connect and empathise with others in order to recognise personal spiritual care needs, (Chapter Two, 2.7.1; Chapter Ten, 10.3.1.2). These ideas resonate with the availability and vulnerability framework for nurses presented by Rogers (2016).

Rogers (2016), proposed a model for availability and vulnerability and explained that self-awareness and critical reflection on one’s inner life and values were essential to develop spiritual care competency. Self-awareness and an understanding of personal quest can enable the learner to develop healthy, caring relationships and authenticity in their professional role (Brown, 2010; Thorup et al., 2012) Practitioners (and students) aware of their own needs for spiritual nourishment may be better able to develop resilience against burnout (Brown, 2010). Rogers (2016) further explains the

concept of vulnerability by emphasising authentic presence, effective listening, hearing the unsaid and being non-judgemental towards others. Being vulnerable with others can also promote congruence and empathy to offer compassionate care.

11.3.1.3 Religious affiliation

Religion and spirituality are often found as over-lapping concepts in nursing and health care in general (Greenstreet, 1999; Lemmar, 2010). McSherry (2000a), presented a critical analysis of both historical and traditional teaching approaches that are influenced by socio-political and religious factors due to which integrating spirituality in nursing is still a challenge. During the present study, students shared their beliefs that “*religion and spirituality is intertwined together*”, (UB-FG/L1409). Such overlap could lead to confusion and ambiguity with reference to encounters between patients and nurses or students and educators due to the complexities of a multicultural society. As a result, a sense of fear of offending others and feeling “*apprehensive*” (UB-FG/L1369), was verbalised by many participants across all cases (Chapter Ten, 10.3.1.3; 10.3.3.1).

In this research participants also shared their concerns grounded in role ambiguity as care providers. Issues such as praying along with patients from other faiths, difference in religious beliefs based on ideologies regarding God (UA, Chapter Five, 5.3.1.3), concepts of heaven and hell, dying rituals and life after death were a source of anxiety and fear (UB, Chapter Seven, 7.3.1.3).

Gordon et al (2011, p. 9) have recognised such tension between religion and spirituality, often leading to dilemmas in care:

Understanding spirituality is further complicated by the common misconception that spiritual care and religious care are one and the same thing. Many healthcare professionals say the word “spiritual” but in their head, are thinking “religion”. The secular agenda, on the other hand, tries to remove religion from spirituality... neither of these approaches is helpful.

Due to personal value conflict and diverse beliefs, and lack of role clarity, especially among student nurses, most participants expressed lack of confidence as “*holistic care is not for every practitioner*” (UA-FG/103), and recognised the need for more clarity and preparedness to address spiritual care

needs. For some participants, spiritual care needs were seen as a matter largely or only for specialist chaplains, as mentioned “*I don’t feel that authority, feel very uncomfortable talking about these [spiritual care aspects]*” (UC-Int02/L1959-1962); hence not relevant to nursing practice beyond making an appropriate referral (Chapter Seven, 7.3.3.1).

This research identified that spiritual care is not only about effective listening or maintaining privacy and dignity and acknowledging religious needs. Nor can spiritual care components be reliably covered as an implicit embedded concept within the concept of holistic care. The need for spiritual care requires explicit expression and clear representation in the same way that physical, psychological, social and cultural needs are specified. This study revealed that spirituality is a deep, sometimes buried aspect of holistic care, which requires existential and phenomenological recognition. However, existing nursing education, fails to provide that clarity in curriculum documents (Lewinson et al., 2015; Yilmaz & Gurler, 2014; Chan & Chung, 2004; Kalkim et al., 2016; Bennett & Thompson, 2015). During this research educators identified that, “*there is no framework out there for actually how you teach students. Spirituality is part of nursing assessment but mostly nurses find it difficult and as an alien concept*” (UC-Int 04/L1696-1698). Such inadequacy has resulted in varied educational standards with reference to curriculum design and delivery structures as evident through cross-case synthesis (Chapter Ten, 10.3.5). Acknowledging the breadth of the concept of spirituality and its scope of meaning with actualising potential, connectedness and authentic presence opens a new horizon of competency for teaching and integrating spirituality into nursing education.

11.3.2 Choice-based

Both the literature review and case studies supported the idea that addressing spirituality in nursing education is highly dependent on educators’ and students’ personal choices and levels of confidence as well as personal beliefs and environmental factors (Callister et al., 2004, Yilmaz & Gurler, 2014; Timmins et al., 2014; Ross et al., 2014; Kalkim et al., 2016).

11.3.2.1 Personal Comfort and Creativity

During this case study, participants identified that, “*teaching spirituality depends on who teaches and how it is taught*” (UA-Int03/L818-819). Caldeira et al., (2016) also recognised that teaching on spirituality was dependent on personal interest, creativity and work load pressures. In this study

participants reported similar findings based on personal interest, experiences, confidence, clinical priorities and environmental constraints that affected teaching in this area (Chapter Ten, 10.3.2.1).

11.3.2.2 Time and Environment

Complementing several other studies conducted on nursing students this study (Chapter Ten, 10.3.2.2), identified concerns about limited competency and lack of preparedness in relating to spiritual care issues due to time and work load constraints on teachers (Tiew & Drury 2012; Tiew & Creedy 2012; Cooper, Chang, Sheehan & Johnson, 2013; Lopez et al., 2014; Kalkim et al. 2016). Participants identified the time and work load pressure as, *“the standard for pre-registration is tighter and tighter, and things get lost. So, it makes it [relating spirituality in nursing education] more difficult”*, (UA-Int 03/L844-845). This illustrates that nursing education often appears to dichotomise the human phenomenon and compromise quality care by prioritising physiological malfunctioning over psychosocial dysfunction, sometimes leading to tragic results (Francis, 2013). The UKCC (2000) guidelines and NMC (2010) standards for pre-registration nursing, recognised the importance of assessing spiritual needs as part of holistic care, yet failed to clarify how this should be addressed in the nursing curriculum and care standards (McSherry, 2000b; Murray & Dunn, 2017). Consequently, nursing education has continued to prioritise bio-medical or symptomatic aspects rather the existential domain of personal development (Daaleman et al., 2001; Strand et al., 2016).

The concepts of existential and spiritual care have been recognised as abstract and nonfigurative concepts, which are often unacknowledged in health care (Stanworth 1997; White 2000; Murray & Dunn 2017). Due to the mechanical and technical nature of symptomatic nursing care both nursing educators and student nurses focus on these more easily measurable aspects of care. Spirituality does not get adequate emphasis and priority in nursing education (Strand et al., 2016; Wattis et al., 2017).

11.3.2.3 Non-explicit in nursing curriculum

Although there have been an increasing number of scholarly contributions on nursing care and spirituality over the last few decades, there still uncertainty about the place of spirituality in nursing education (Ross et al., 2014; Lopez et al. 2014; Caldeira et al., 2016)

As discussed in Chapter Two, Timmins et al., (2014), studied core nursing texts to explore to what extent spirituality was approached in nursing text books. It was reported that there has been some guidance and direction around spiritual care. However, few provided relevant detail on spirituality. They did not generally, for example, explore the issues around definitions of spirituality, explore the relationship of spirituality to religion or discuss the role of the nurse in assessing spiritual distress. Nor did they offer tools for assessing spiritual care needs in practice. The study recommended that nursing texts should be strengthened by providing a consistent focus on spirituality and including spiritual care themes. Yilmaz and Gurler (2014), explored the efficacy of a revised and integrated undergraduate curriculum compared with a traditional nursing curriculum in Turkey. Their study emphasised the effectiveness of revising an existing nursing curriculum to integrate spiritual care. Caldeira et al., (2016) reported a wide scope for integrating spirituality in various nursing courses and several creative teaching and learning approaches were also identified by the educators. The study identified the need for a standardised curriculum with explicit representation of spirituality through a theoretical and clinical knowledge base, along with suggested teaching strategies.

In this study, all cases reported that, owing to the conceptual complexity associated with the term spirituality, nursing educators often lacked confidence to discuss it in class or relate it to nursing practice. Findings from UA suggested that non-specialist educators avoided classroom teaching about spirituality and tended to enlist help from members of the special interest group for this function (Chapter Five, 5.3.2.1). Data from UB reported that due to conceptual complexity a generalised interpretation of the concept of spirituality, as holistic care was used in nursing education (Chapter Six, 6.3.2.1). For UC, spiritual concepts were highly related to chaplaincy care and religious ritual, especially with reference to terminally ill patients (Chapter Seven, 7.3.2.1). Also, Nursing educators from all cases; mentioned that the NMC was responsible for setting the learning standards for nurse training in England (Chapter Ten, 10.3.2.3).

However, the NMC expects that Approved Educational Institutions (AEIs) are responsible for setting a curriculum based on the established standards:

We set the standards that approved education institutions (AEIs) must keep to, as well as the standards that student nurses and midwives must meet to enter and stay on our register. However, we do not set the curriculum that students follow as individual AEIs are responsible for setting these. Our pre-registration nursing and midwifery standards include, the minimum length of pre-registration programmes, the criteria to be met at progression points, and the core competencies that all students must meet in order to progress through their programme and gain entry into the register (NMC Standards, 2015, npn).

Another document from the NMC stressed that one of the Council's roles is to enable educational institutions to shape the content and design of programmes, but that the NMC is neither responsible for educating students nor setting up the curricula for them (NMC-Education, 2015). The NMC sets standards, learning outcomes and assessment criteria:

We are required under the Nursing and Midwifery Order 2001 (the order) to establish standards – minimum requirements by which programme providers determine programme content, learning outcomes and assessment criteria (Nursing and Midwifery Council, 2010, p. 5).

The document which sets standards for pre-registration nurse education specifically mentions that nurses should take account of spiritual issues when making an assessment:

All nurses must carry out comprehensive, systematic nursing assessments that take account of relevant physical, social, cultural, psychological, spiritual, genetic and environmental factors, in partnership with service users and others through interaction, observation and measurement (NMC 2010, p.18).

The NMC offers flexibility to all learning institutions in setting up the curriculum and structuring student-centred assessment based on the progression criteria. However, the efficiency and effectiveness of such flexibility in designing the curriculum and structuring the competency framework for both educators and students is not clear. As identified in Chapter Six, UB did not have any formal

document as a set curriculum to be used for the undergraduate nursing programme. In UA and UC, as discussed in Chapter Ten; modular based course grids were used. Thus, whether the undergraduate nursing curriculum should be left open to personal choices of educators and institutional priorities or guided by the professional needs of student nurses remains a challenge for learning institutions.

11.3.3 Question of Authority

In this study, concerns related to authority issues due to multicultural beliefs, fear of giving offence and anxiety due to personal values; were reported by most of the participants, across all three case studies (Chapter Ten, 10.3.3). These findings are further discussed below:

11.3.3.1 Fear

Some student nurses and educators avoided any discussion about spirituality in nursing education because of an underlying fear of offending others. A more homogenous culture with a dominant religious affiliation was easier to deal with as lack of clarity about other belief systems in a multicultural setting may lead to uncertainty and fear of causing distress (Chapter Ten, 10.3.3.1). McSherry, et al. (2008) reported that students often associated spirituality with existential ideas and were uncertain about making judgements on or being instructed in spiritual matters because of fears that it would be unethical to comment on individual values and belief systems. Narayanasamy (2014) reported the ambiguity and discrepancies in governmental policies and curriculum overlooking the issues of cultural and religious diversity with reference to spiritual care needs of NHS patients. These often resulted in confusion and avoidance of discussion about spiritual care in nursing education.

Since the concept of Spirituality is fundamentally rooted in personal experiences, influenced by cultural and religious ideologies and political context, adopting a narrow-unified view and fixed definition in health care is an inappropriate response to resolving confusion and the avoidance of spirituality in nursing education (Swinton, 2001). However, Gordon et al (2011, p.13) stress that: "*The key to providing spiritual care is to understand what spirituality means to the person you are caring for.*" It is vital to prioritise care according to the specific personal, cultural and spiritual needs of a patient rather than just offering a generalised technical care on the basis of similar signs of a disease process. Hence, dynamic, congruent and meaning- making professional relationships between

patients and health care professionals are favoured (McSherry et al., 2004; Gordon et al., 2011; Clarke, 2013). There is a dearth of research identifying the required competencies for nursing educators in preparing nurses competent to identify and respond to spiritual care needs (Cone and Giske, 2012).

11.3.3.2 Role confusion: Nurses or chaplains

As discussed in Chapter Ten (10.3.3.2), some participants (especially in UC) felt that spiritual care competency was only related to chaplaincy services. Some attributed this to work pressure and thought it was a nursing priority to deal with more 'clinical' matters. It would appear that, contrary to NMC standards (2010), some students did not see assessment of spiritual needs as an essential requirement to be integrated in education and practice. Arguably, care is defined as response to recognition of a need (Tronto, 1993). However, the dominant bio-medical medical model generally emphasises the objective, measurable, disease based, physiological aspects of care. Assessment of patients is generally based on a clinical framework which seeks information on medical history, examination and investigation, demographic details, social lifestyle, dietary patterns and religious affiliations. This assessment is then used to develop a medical diagnosis, plan nursing care and refer the patient to specialised services (Martinsen, 2010). In this study, all students reported that filling out the nursing assessment form and referring patients to chaplaincy care, when appropriate, were the major role expectations of student nurses. However, only referring patients to chaplaincy services does not constitute holistic care, nor can it be justified as the only professional role of a nurse with respect to spiritual needs (Bunard, 1993; Greenstreet 1999). There is a need to establish role clarity towards the professional responsibility of a nurse through nursing education, to empower student nurses in recognising and addressing the spiritual care needs of their patients.

Barss (2012a) identified some barriers which included the lack of recognition of the relationship between general health and spiritual care, insufficient time for students to provide spiritual care due to prioritising physical complaints, and role ambiguity of both students and educators when offering support in cases of spiritual distress. At present, there is a deficiency in understanding how the competencies to address the spiritual care needs of patients are developed in student nurses through nursing education (Caldeira et al., 2016). In addition, with reference to the existing nursing curriculum,

Benner et al., (2010) claimed that current nursing education does not adequately prepare nurses to connect with patients' existential and spiritual dimensions. Denying these aspects of the nurse-patient relationship alters that relationship and may adversely affect therapeutic efficacy (Bennett & Thompson, 2015). Further work is needed to explore the nature of the knowledge gaps, philosophical constructs and educational initiatives needed to overcome this persistent defect in nursing education.

This research identified certain political factors that influence the knowledge-seeking and practice approach in nursing education. Clinical priorities based on disease- centred care appeared to take priority over person-centred care. Work load pressures and time constraints were advanced as reasons for avoiding addressing spiritual issues in some cases, even when the nurse wanted to do this. During one focus group study, it was mentioned that due to other clinical priorities a student nurse, *"left the patient... ignored it [spiritual care needs] ..., shut her [patient] down.* (UB-FG/L1437-1439; Chapter Ten, 10.3.2.2)

These influences constitute a hidden curriculum, both in nursing education and practice that determines the nature and extent of integrating person-centred care and attention to spiritual needs compared with a disease based approach. The hidden curriculum has been defined as, the *processes, pressures and constraints which fall outside the formal curriculum and which are often unarticulated or unexplored* (Cribb & Bignold, 1999, p.24). The present research also highlights the need for further investigation into those factors that influence nursing education through this hidden curriculum.

Clearly holistic care should embrace spiritual care but often spiritual care needs were overlooked during teaching and learning activities owing to cultural and political influences that favoured a mechanistic disease- centred care approach that is more easily measurable and more suited to a target driven management culture (Wattis et al., 2017). Over the last two decades there have been a number of calls to integrate spiritual care into nursing education (Narayanasamy, 1993; Benner et al., 2010; McSherry & Jamieson, 2011; Yuan & Porr, 2014; Ross et al., 2014; Lewinson et al., 2015), but there is no consensus about how this can be done.

McSherry and Draper (1997) emphasised the need to address those socio-political determinants that ultimately influence whether spirituality is regarded as a legitimate aspect of nursing education and practice. Lack of role clarity, inadequate representation in the nursing curriculum and ambiguity within the NMC code (2015) further complicate the articulation of spirituality for nursing educators and students (Prentis et al. 2015; Rogers, 2016).

As highlighted in Chapter Ten, based on institutional priorities and policies, each nursing school is free to adopt any suitable approach to meeting NMC standards for pre-registration training (2010). However, spiritual care receives little attention in nursing education (Timmins & Neill, 2013; Ross et al., 2014; Lewinson et al., 2015). In addition, the present study revealed that generally clinical assessments recognise spiritual care aspects by merely ticking the box on religious affinity and referring patients to pastoral care services. Whilst, the NMC standards, (2010) and NANDA (2014) consider spiritual care to be a legitimate assessment area in nursing care, the NMC code (2015) contains no explicit mention of spiritual needs. More clarity and explicit representation of the term spirituality and spiritual care needs is required in nursing education. This aspect of holistic care should not be left to the personal choices of educators and practitioners.

Several teaching and learning methodologies to incorporate ideas of spirituality into nursing education and practice have been proposed (Nardi et al., 2011; Cockell & McSherry, 2012; Cone & Giske, 2012). However, perhaps partly because of the difficulty in conceptualising spiritual care and confusion amongst nursing educators in approaching the concept of spiritual care, the issue remains inadequately addressed in nursing education. This may also be due to secularised influences on contemporary health education; resulting in a relative overemphasis on narrowly-defined, evidence-based and empirical learning outcomes. This focus on an evidence-based, empirical approach to disease and symptoms can lead to the neglect of spiritual and existential care (Daaleman et al., 2001). Though person-centred care is emphasised in theory, in practice the major emphasis is on narrowly defined evidence-based clinical interventions and outcomes (Benner, 1994; Martinsen, 2006). In theory, spiritual care is recognised as an aspect of holistic care. However, there are major issues in approaching spirituality in practice. Some of the possible reasons for this including the complexities surrounding the concept of spirituality, the dominant “mechanical” biomedical healthcare

culture and the issues of working in a multicultural society all of which may help explain why this area is so hard to address in practice.

To help overcome the political influence of a disease-based approach over person-centred care, I propose a teaching framework grounded in the work of this thesis. This is based on the self-awareness needed to address the ontological task of becoming a nurse and the Phenomenological nature of the subjective interaction with patients grounded in a Humanistic approach that takes into account Ideological distinctions between different cultures and religions and the Existential nature of spiritual issues. I have given this the acronym SOPHIE and will develop the concept further in section 11.3.5.

11.3.4 Spirituality can/ can't be taught

There have been extensive debates on whether formal teaching of spirituality could prepare nurses to deliver quality care or whether this aspect of caring behaviour is determined by the personal traits, morality and vocational motivation of each nurse (Ross, 1994; Bradshaw, 1997; McSherry et al, 2008). Nevertheless, several approaches have been used to approach spiritual care aspects of nursing education (Lewinson et al., 2015; Strand et al., 2016). In this study, approaches to teaching and learning about spiritual care in nursing were reported to be based on the individual personalities, personal vocation and life experiences of both educators and students. However, many participants affirmed that caring values and reflective practices could be reinforced through formal and informal teaching sessions. Recent studies on students also showed that nursing students should understand their own spirituality before approaching patients' spiritual issues and that students were likely to have a range of perspectives on spirituality based on personal and professional exposure (Lopez et al., 2014; Ross et al., 2014). This finding is complemented by the present research as students related spirituality to their own selves first. Also, they wanted more support from educators for self-understanding about their own spiritual needs (Chapter Ten, 10.3.4.2). The notion of vocational based nursing practice in relation to spiritual care and common concern for developing a shared understanding on learning about spirituality is further presented and discussed in the following sub-themes:

11.3.4.1 Vocational based

When the participants were asked whether spiritual care could be taught; the common answer from the educators was that since nursing is a vocation-based profession, spirituality and caring values cannot be taught to students only through formal classroom teaching (Chapter Ten, 10.3.4).

Participants also related spiritual care to compassion as the core nursing value, explicitly recognised as the 6 C's (care, compassion, competence, communication, courage and commitment) in both nursing education and practice (NHS, 2012). The 6 Cs are the established ethos in nursing to ensure that patients are receiving, consistent quality care, as the core of nursing philosophy. These values are expected to be embraced by a nurse; not as additional clinical tasks, rather as a professional identity *being* a nurse (McSherry 2006; Pfeiffer et al., 2014). However, out of these 6Cs. only competency could be rationalised and justified as an evidence based and 'scientific' concept. The other 5 Cs are the qualities, approaches, and behaviours that cannot be formally taught (Cox, 2013). This put becoming a nurse in the ontological sphere alongside other occupations traditionally considered as vocational, especially medicine. Martinsen (2006) therefore, refers to nursing as a commitment to own self and vocational rather than a task oriented profession. The concept of vocation in nursing care is rooted in the historical foundations laid by Florence Nightingale who described a nurse as one who received a call from God to care for others (Lundmark, 2007). However, there are critiques on whether nursing is vocational or whether it is solely based on a contractual relationship like many other occupations (White 2002; Lundmark, 2007). White (2002), discussing the epistemological value in nursing care, related the concept of vocation in nursing to a meaning-based commitment:

The nurses responded not in their own interests, but for the patient and for the sake of the patient. The personal identification with and, indeed, the claim of ownership of, the social meaning of nursing, helps to structure the identity of the nurse and thus creates the 'moral pull' that nurses feel towards tasks involved in caring for patients. The personal meaning of a vocation requires a commitment to act in the appropriate ways and, insofar as the commitment is conceived to be a moral one, the personal meaning passes over into a moral one (White, 2002, p. 284).

During the present research, educators shared their expectations that students should develop their professional identity as empathetic and compassionate carers (Chapter Ten, 10.3.4.1). Also, many educators emphasised that due to the value-based recruitment process, only students with the potential to develop these values should get through the admission process. However, when students were asked about their views not all participants agreed to the idea of a personal vocation to be trained as a nurse. Professional identity is often related to the self-concept of student nurses (Kroger & Marcia, 2011). It explains how nurses think and feel about their caring role and professional relationship with patients (Johnson & Cowin, 2012). Student nurses develop professional identity as a result of self-awareness about personal competencies and commitment to practice standards (Björkström et al., 2008). Hence, undergraduate education plays a key role in developing the professional identity of a nursing student. Through classroom teaching and clinical practice student nurses learn about their professional accountability. Johnson & Cowin (2012) explains that student nurses construct and deconstruct their professional identity through and throughout their learning experiences. Professional identity not only reflects on student nurses' judgement in pursuing nursing as career, their academic and clinical performances, but also influences on the severity of burn-out and retention rates as nursing graduates. A congruent professional identity leads to role clarity and confidence in student nurses. The process of education, interaction with their educators and mentors and the entire learning environment enables a student nurse to become a professional. Based on Carl Rogers and Martinsen's work, Brown (2012) asserts that It requires authenticity to develop meaningful and empathetic relationship with others. Also, it involves willingness of a nurse to be available, vulnerable to patient's need (Rogers, 2016).

As identified in Chapter Two (2.8.1), developing authenticity is the fundamental requirement to prepare nurses to offer spiritual care. Being authentic means being fully human, open and transparent to others in order to acknowledge others' needs as human (Schmid, 2001). It enables a nurse to offer a meaning-based care, where her/his own self is willing to be available for others (Pollard, 2005; Brown 2010). Schmid (2001) explained that authenticity is reflected through congruence, unconditional compassion and empathy for others. However, this does also mean to maintain professional boundaries (Rolheiser, 2004). Schmid (2001) suggested that being authentic enables congruency in nursing presence. Hence first it requires honesty and compassion with respect to one's

own personal needs, so that an open and transparent caring relationship can be established with others. Educators need to be able to facilitate the development of authenticity in nursing students as, through the process of professional socialisation, interaction with their educators and mentors and the entire learning environment a student nurse is enabled to become a professional (Hood & Leddy, 2006).

The role of nursing educators and clinical mentors becomes very critical here to orientate students to professional values, skills and competencies (Andrew et al., 2009; Kroger & Marcia, 2011). Students may develop their professional identities with a feeling of inadequacy, incompetency and lack of confidence in their professional roles due to negative role modelling or lack of motivation (Prato et al., 2011). There could be a negative influence on student nurses' professional identity due to ineffective relationship dynamics between educators and students or due to a mismatch of what a student learns in theory and what happens in clinical practice where care priorities are affected by work load and time constraints in the care environment. The current study also reported that, in all case studies, students identified their confusion and a need to develop role clarity towards spiritual care (Chapter Ten, 10.3.3.2). During one of the focus groups in this study, (UA-Chapter Five, 5.3.2) students mentioned how important it was for them to see their educator as their role model integrating spiritual care in education and clinical tutorials: "*if something you are not teaching or teaching how to approach it, student is not likely to apply it*" (UA-FG/L145-149). Cone and Giske (2012) found that role-modelling and mentoring supported students in developing insights concerning spirituality and spiritual care need. Positive role modelling, continuous mentorship, and tutorials could be vital strategies (Chapter Ten, 10.3.4.2) to complement class room teaching and threading spirituality through both theory and practice (Johnson & Cowin 2012; Strand et al., 2016).

Educators and student nurses emphasised the importance of effective mentorship to adequately address spirituality in nursing education. As discussed in Chapter Ten, (10.3.2.3, 10.3.5); educators were not clear about role expectations and professional requirements from NMC with respect to spirituality as an explicit aspect of nursing education and practice. Sometimes this resulted in a deficiency in the professional identities of both educators and students. Perhaps without nurturing the professional identities of both educators and students to bring confidence and competency, embracing spirituality in nursing education will remain difficult.

Throughout this study students' knowledge about spirituality and care giving practices was largely influenced by the intrinsic motivation factors they developed and nurtured through personal values and the professional encouragement they received from their educators (Brown, 2010; Thorup et al., 2012). Also, for nursing educators, it was purely their intrinsic motivation, based on their personal belief and experiences, which guided them to integrate spirituality in their professional commitment through formal or informal teaching and support offered to students (Chapter Ten, 10.3.2.1). For students, learning to approach spirituality through small tutorials or peer group discussion was more engaging and productive as than large classroom teaching sessions. Students' personal interest, and attention focused by educators on spirituality were motivational factors that positively influenced students to offer care addressing the spiritual and existential care needs of their patients (Chapter Ten, 10.3.4.2). Arguably, spirituality constitutes a fundamental philosophical ground in nursing care and cannot be ignored or overlooked due to personal motivational factors. Therefore, professional values such as self-determination and motivation become eminent in understanding how nurses approach spiritual care. According to Cokley (2000) self-determination and motivation has a direct relationship to educational outcomes that mark a student's consistency, engagement and commitment to care. Deci and Ryan (2000) characterised motivation as intrinsic or extrinsic inspiration, based on personal experiences. Ryan and Deci (2000, p. 70) asserted that *"perhaps no single phenomenon reflects the positive potential of human nature as much as intrinsic motivation, the inherent tendency to seek out novelty and challenges, to extend and exercise one's capacity, to explore, to learn"*.

In addition to intrinsic motivational factors, the research identified several extrinsic factors acting on educators that limited their engagement with spirituality in nursing education. These included administrative pressure to finish the curriculum within the set deadlines by the course leaders, preparing students to meet programme outcomes through evidence-based assessments and environmental constraints in setting clinical priorities in acute care settings (Chapter Two, 2.7.3; Chapter Ten, 10.3.2.2). During the present study, participants raised their concerns about the time constraints, clinical priorities, environment and work load pressure as external factors that affected their opportunities and ultimately their motivation to offer person- centred care and address patients' existential and spiritual care needs (Chapter Ten, 10.3.2.2). There is a need to pay attention to

motivational factors and develop professional understanding and educational practices that can strengthen the internal and external motivations to address spirituality in nursing education and practice.

Barnett and Coate's (2005) work on engaging the curriculum in higher education could be a way forward to establish an active and transformational relation between student nurses and educators. Their concept is of a tripartite curriculum that engages educator and students at three different levels. These are knowledge sharing (epistemological), being and becoming (ontological) and performance (skills and action). This emphasis on ontological aspects is particularly suited to developing the vocational aspect of nursing which depends on who the nurse is as well as what they know and can do. However, self-determination is required to establish professional identity and authenticity towards personal and professional responsibilities. This research identified that self-determination, professional engagement and personal commitment are equally relevant to develop spiritual care competency in both students and educators (Chapter Ten 10.3.4). One strategy to enable self-determination among learners and educators is to create and acknowledge personal ontological space (Halsall et al., 2016; Snowden et al., 2016) and commitment to availability (Rogers, 2016). Self-determination in respect of learning can enable understanding of the nurse's own spiritual needs and develop competency in acknowledging spiritual care needs in others. The educational environment and learning systems are also responsible for determining the extent and quality of learning (Chapter Ten, 10.3.2.3). Due to the political influence of the learning environment, learners may become motivated or demotivated towards a desired skill or competency or towards personal development (Barnett, 2012; Snowden & Halsall, 2014). The educational environment is one of the important factors that encourages learning by determining, when, how and what is to be learned. This environment can either promote or inhibit the choice of what is learned and what skills and personal qualities are developed (Snowden et al., 2016). The present research identified environmental constraints and aspects of the nursing curriculum and the clinical environment that influenced the extent of engagement of students and educators with aspects of spiritual care (Chapter Two, 2.7.3; Chapter Ten, 10.3.2.2). However, self-determined learning can enable new learning possibilities through empowering learners in shaping their own ontological spaces and taking responsibility for self-development (Barnett, 2012; Snowden et al., 2016). This approach allows learners to design their

own learning, based on their personal and professional experiences, embracing their own authentic selves and developing their own sets of values towards learning and growth. This learning process is known as a heutagogical process where the learner actively participates as partner with the educator and curriculum (Hase & Kenyon, 2013) rather being a passive knowledge recipient. This involves a potential risk if students are not able to take such responsibility or struggle with personal transformation within their ontological spaces. Educators have a vital role in engaging students in reflective discourse and assuring their presence for the required facilitation (Canning, 2010; Barnett, 2014).

Bhoyrub et al., (2010, p. 324) have noted that:

"[...] learners are seen as only facilitated toward learning, rather than being directly taught. This facilitation reduces the opportunity for the learner to experience being under threat, subsequently allowing a relaxation of ego boundaries and hence being more open to learning. Effective learning environments can consequently be seen as those that minimise threat to the self and that promote differentiated perception of experience [...]".

Also, a transformative learning strategy could be an effective approach to bring students closer to their own selves; realising the meaning associated with their potential roles as nurses (Snowden & Hardy, 2012, Mezirow, 2000).

As discussed in Chapter Seven (7.3.3.2), some participants related spirituality primarily to chaplaincy services, in the setting of terminal illness or near-death situations. They could not see the need for providing spiritual and existential care, particularly in acute clinical crisis situations. Heutagogical interventions, based on transformative learning philosophy could be useful in addressing such issues of role confusion developed as a result of professional ambiguities, with reference to practicing and applying spirituality across various clinical and non-clinical settings. Engaging students in a transformative meaning-making process is a way to enhance their role clarity as a holistic care provider. Through solution focused learning and mentor facilitation, learners can be provided with an opportunity to recognise their personal set of meanings and values associated with being student's nurses. This may equally be applicable

to nursing educators where through peer support, or mentorship, they may acknowledge personal fears, anxieties and level of confidence that may hinder them in fulfilling their role as competent educators to discuss spirituality with their students (Snowden & Hardy, 2012; Snowden & Halsall, 2014; Halsall et al., 2016). Based on ontological learning approaches and acknowledging the reflexivity required to develop spiritual care competency, a competent curriculum structure is required for undergraduate nursing education that can embrace nursing ontology as part of development for professional practice (Stern & James 2006; Wattis et al., 2017).

11.3.4.2 Quest for developing shared understanding

As, discussed in Chapter Ten (10.3.4.2), participants recognised the need for a shared understanding of spiritual care in relation to nursing education. Despite some students having a religious background, several studies have reported the student's quest for more confidence and clarity to approach spiritual care through nursing education (Tiew & Drury 2012; Tiew & Creedy, 2012; Cooper, Chang, Sheehan & Johnson, 2013; Lopez et al., 2014; Ross, et al. 2014; Kalkim et al., 2016).

Fostering partnership between students, educators and clinical mentors, can also facilitate positive role modelling by reducing the gap between knowledge and the practice environment. Collaboration and connections between university and hospital environments have been demonstrated to influence positively students' mentor relationships and positive learning outcomes (Ware, 2008; Swinny & Brady, 2010). A good partnership between the teaching university and hospital settings resulted in positive learning outcomes in extending understanding and confidence in applying spiritual care (Wallace, 2008; Strand et al., 2016). By developing a shared teaching and practice framework to integrate spirituality as an explicit aspect of person- centred care, as suggested by the research participants in this study (Chapter Ten, 10.3.4.2), student nurses can be supported to learn how to organise knowledge and attain the professional role enabling them to embrace spirituality in nursing. Effective collaboration and role clarity could be developed through a learning framework (Chapter Ten, 10.3.4.3) to be mutually followed, agreed and practiced by educators and mentor to develop a professional congruency in knowledge delivery and practice (Johnson & Cowin, 2012).

A realisation during this study was that spiritual care belonged in the phenomenological area of interpersonal connection and idiographic knowledge rather than purely technical (nomothetic) knowledge or skills (Swinton, 2012). This places education for spiritual care firmly in the area of personal and professional development, the ontological sphere of being and becoming (Kang, 2003). This was recognised by participants in the study who acknowledged the limitations of classroom teaching in this area and the importance of mentoring and role modelling (Johnson & Cowin, 2012). This was also reflected in the literature (Sawatzky et al., 2005; Martinson, 2006; Rogers, 2016). I therefore explored the literature on nurse education more widely and found that this kind of developmental approach could be fostered by self-exploration and even self-directed learning. Recognising the centrality of ontological development to this area and based on my reflections on the findings of this study, I have developed a tentative framework for nurse education about spirituality which also addresses existential and cultural issues within a broadly humanistic framework. I have given this framework the acronym SOPHIE and discuss it in detail below.

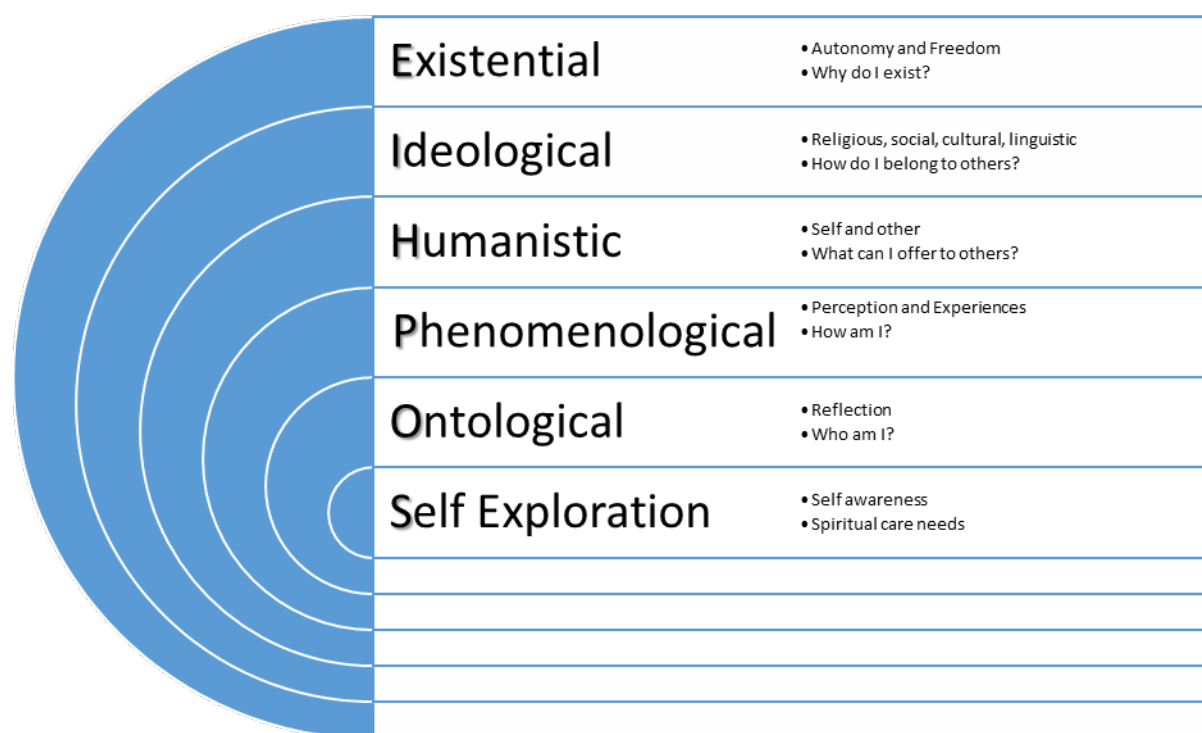
11.3.5 A potential framework for professional development of nurses - SOPHIE (Self-exploration through Ontological, Phenomenological, Humanistic, Ideological, and Existential expressions)

SOPHIE (Self-exploration through Ontological, Phenomenological, Humanistic, Ideological, and Existential expressions) is a framework which could be used both as a teaching and need assessment tool in nursing education, and across health care in general.

SOPHIE: An Expression of Self – Expansion

SOPHIE, the diagram (Figure 5) represents symbolically the development of an expanded self. It also symbolises, a drop in the ocean in search of its own existence. The drop that remains in flux and can never be confined to any given point, yet actualises its existence through infinite waves. Each circle in the diagram represents a wave and its journey of growth and expansion. The detailed description of each component is discussed below:

Figure 5: SOPHIE- A framework for approaching spiritual care need.



a. Self-exploration- I v/s Me?

Self-exploration requires recognising personal beliefs and experiences that have an effect in developing an authentic and congruent self (Rogers, 1959; Carlin et al., 2012). By acknowledging personal strengths and recognising needs for self-development, a person can identify reasons of developing in-congruency between meaning-making and behavioural choices (Sawatzky et al., 2005; Thorup et al., 2012). By taking charge of one's own thinking pattern, feelings and behavioural responses towards a given situation, an empowered, motivated and determined self can be developed (Johnson & Cowin, 2012).

b. Ontological Aspect-Who am I?

The ontological aspect enables exploration about the personal sense of “being and becoming”, in this world (Kang, 2003). It allows participants to engage with the philosophical reasoning associated with the meaning of their existence in the given time. Such exploration can be effective in articulating understanding of purpose, and meaning in life. Ontological understanding may be helpful to identify

personal resources of hope and connection (De Carvalho, 2000; Kierkegaard, 2000; Martinsen, 2006; Rogers, 2016)

c. Phenomenological aspect- How am I?

The phenomenological domain explores one's perceptions, feelings and experiences in the given situation. It may allow participants to understand the process of healing through intentionality (Zahourek, 2005). Intentionality has been defined as, "focused attention" or "mental projection of awareness, with purpose and efficacy, towards some object or outcome, such as promoting change in one's self or another" (Braud & Schlitz, 1991, p. 31). Hence, by exploring one's thought constructs, affective responses and behavioural reactions, one can develop insight about feelings and responses developed in the given situation. This exploration could also enable health practitioners and educators to explore factors affecting individual coping and resilience in crisis, (Martinson, 2006; Rogers, 2016).

d. Humanistic aspect- What can I offer to others?

This domain identifies how one's self is presented in society for others (Carlin et al., 2012). It allows participants to explore the extent of self-availability. Self-extension could be achieved by acting compassionately, offering caring presence, effective listening and by providing existential advocacy for others (Benner et al., 2010; Rogers, 2016). By exploring the humanistic dimension, participants can recognise their strengths and areas of challenge in relating to others (Watson, 1999; Sawatzky et al., 2005). Such realisation may help participants to overcome emotional and behavioural resistance, hindering the realisation of personal potentials (Newman 1999; Flaming, 2004).

e. Ideological aspects- How to I belong to others?

This domain explores religious, cultural, social, political and linguistic aspects that affects self-identity within a given context. Knowledge of such affiliations enables practitioners and students to acknowledge various values, beliefs, doctrines and traditions and to maintain the privacy and dignity of their patients (Narayanasamy, 1999b, Johnson & Cowin, 2012).

f. Existential Aspect-Why do I exist? What is the meaning of my life?

This aspect focuses on one's quest in life. It allows participants to explore what influences their identity constructs and how it often affects their wellbeing (Kang, 2003). Such exploration could be useful in recognising the meaning of suffering and hope in one's life. This domain could be highly useful in exploring identity crisis, gender issues, sexual anxieties, social fears, nature of loss and pain, affecting personal growth and recovery (Sartre, 1956; Frankl, 1969).

11.3.5.1 Scope of SOPHIE:

Embracing the philosophy of nursing ontology and existential phenomenology, SOPHIE is designed to provide a framework for realising the authentic self that establishes the basis for addressing spiritual issues. The authentic self, embraces ontological, existential and ideological aspects of the person and establishes autonomy and empowerment towards self-governing moral principles (Schneewind, 1998; Dworkin, 1988). However, if there are conflicts in realising personal autonomy within the ethics of authenticity then it may lead to self-disintegration and crisis (Ferrara, 1993). SOPHIE provides a framework to enable learners and professionals to establish an authentic personal and professional identity.

SOPHIE focuses more upon the existential meaning of personal wellbeing to understand the process of meaning-making and attitude formation that affects the formation of self and self-transcendence as an optimum notion of wellbeing. Many existential and phenomenological studies have recommended spiritual and existential domains as vital aspects to be understood and cared for. However, their integration in nursing education remains a challenge (Whitehead, 2003; McSherry and Jamieson, 2011). Several nursing theorists have recommended that nurses should embrace transformative practice Newman (1994 p. 116), for example, states that, 'whatever transforms you, transforms your practice'. The nurturing aspect of nursing care accelerates the process of developing self-awareness in a patient by expanding subjective consciousness and enabling transcendence on an intuitive level (Newman, 1999).

SOPHIE, starts with the idea of self-efficacy which has been referred to as "*people's beliefs about their capabilities to exercise control over their own level of functioning and over events that affect their*

lives" (Bandura, 1997, p. 257). SOPHIE has potential to recognise the areas requiring personal and professional attention to focus upon the lost self within a person as a result of social encounters. It can be seen as a reflexive framework for recognising the meaning and tensions behind one's social interactions (Mead, 1934) and health seeking behaviours.

On the basis of the research findings, SOPHIE could be used to achieve the following aims in nursing education.

11.3.5.1.1 To develop authenticity:

SOPHIE is an attempt to access spiritual needs of a person that are often ignored due to clinical priorities that limit holistic care and wellbeing. SOPHIE demands deep reflection from the participants to engage in realising creativity, transformation, and empowerment during the care-giving discourse. To apply SOPHIE, the care-giving discourse could happen between students and educators, educators and mentors, or between health care professional and patients to facilitate self-awareness about personal fears, inhibitions and ideological conflicts. This study confirmed that addressing spirituality often triggers anxiety and fear of offending others. This can result in avoiding discussion on spirituality in nursing education or considering it as a specialised area to be dealt with by professionals with expert knowledge such as chaplaincy services. SOPHIE, could also help to resolve the role ambiguity of nursing professional in addressing spiritual care needs by nurturing confidence, professional authenticity and empowerment. For educators, this framework could be a source of direction that allows some meaningful discussions about existence and articulation of self, while distinguishing the role of a nurse from that of chaplain.

11.3.5.1.2 To provide a matrix for teaching and mentorship

With reference to teaching spirituality as a structured course in the undergraduate nursing curriculum, there were several views shared by the participants. Some participants suggested that it was essential to have teaching sessions on spirituality, to promote students' self-awareness about spirituality and spiritual care needs. But, some believed that spirituality was vocationally based and could never be taught and assessed via formal teaching but needed a developmental approach. SOPHIE could be an effective resource to develop both an underlying theory and developmental

practice for students and nursing educators. The framework of SOPHIE could be used for developing self-awareness to promote self-efficacy and self-determination. It could be useful for teaching and learning where students could explore their own spirituality and spiritual care needs by reflecting on their own behavioural responses and belief patterns. For educators and mentors, this framework could be a source of direction that allowed meaningful discussions about existence and articulation of self in the given context.

11.3.5.1.3 To develop spiritual care competency

During the research study, it was clear that spiritual care is often subsumed into holistic or person-centred care or even confined within the religious domain. SOPHIE is a response that recognises several essential components to approaching and addressing spiritual care need.

The literature review explored some of the validated models and tools developed to address spirituality in nursing education and practice. SOPHIE is a unique way to address transcultural ('Ideological') aspects referred to in the ASSET model (Narayanasamy, 1999a), phenomenological aspects addressed in the TRUST model (Barss, 2012a) and existential aspects addressed by the SSCRS (McSherry et al., 2002). In addition to socio-cultural, behavioural and person-centred approaches, it acknowledges ontological dimensions and embraces intentionality, reflexivity and creativity. This can help student nurses to develop professional congruency to offer existential advocacy. This in turn can facilitate patients in developing self-efficacy and exercising autonomy. By recognising the underlying causes for existential pain and suffering, this framework could be useful for student nurses to recognise the areas of advocacy and the patient's cry for empowerment. This could be achieved by: recognising thinking habits, behaviour patterns, unhealthy life styles and ineffective coping mechanisms. Based on the spiritual care need assessment, students can learn to facilitate their patients in developing ways of effective coping; by taking control of their lives and recognising personal spiritual assets that can make a person more resilient and creative.

Further research is required to evaluate the efficiency of SOPHIE in teaching and learning practice. Such innovation in nursing education calls for accepting spirituality as an explicit and essential learning domain for fostering a shared understanding and professional empowerment.

11.4 Chapter Summary

Spirituality has been identified in the literature and through this study as an abstract and broad concept. Challenges were identified in addressing spirituality in nursing education. These challenges included fear of rejection by offending others, confusion related to role expectations of nursing professionals, and the inadequate representation and emphasis on spiritual care in the nursing curriculum.

Also, this research identified underlying issues leading to this knowledge and practice gap in nursing education. These included discrepancies in educational delivery, as there was no standardised nursing curriculum for the undergraduate programme in the United Kingdom. Spirituality has been recognised as being at the core of nursing philosophy but the NMC appears ambivalent about it including spirituality in its standards for undergraduate nursing (NMC, 2010) but not mentioning it specifically in its professional Code (NMC, 2015). Considering the findings from the literature review on spirituality in nursing education, this study and the educational literature this thesis proposes that approaches to education in this area need to focus on personal and professional development rather than the usual focus on technical knowledge and skills. SOPHIE has been proposed as a framework based on a foundation of ontological development, phenomenological understanding, humanistic principles and engagement with ideological differences and existential experience.

Chapter Twelve: Reflexivity

12.1 Introduction

This chapter introduces the concept of reflexivity and explains the importance of reflexivity particularly with reference to case study design, as a qualitative method. By highlighting different stages of the study, this chapter explains how reflexivity was established as an inbuilt process during the entire process of research to maintain validity, reliability and quality control.

12.2 Importance of Reflexivity

The process of reflexivity is essential within qualitative research throughout the various stages of the entire study (Finlay, 2002; Bryman, 2008; Holloway and Biley, 2011). According to Spencer et al., (2003), it is the process of reflexivity through which a researcher demonstrates self-awareness, personal values and acknowledges pre-assumptions that could influence the findings. The term reflexivity is often confused with reflection, and the terms seem sometimes to be used interchangeably. However, reflexivity can be distinguished from the process of reflection; as reflection is the thought process and verifications of the participants. Reflexivity, on the other hand, has been defined as the process of looking back on the researcher's thoughts again (Woolgar, 1988; Hammersley & Atkinson, 2007), often described as, 'gaze to the self' Shaw (2010, p. 234). In the sections below, I have discussed how reflexivity has always nurtured me throughout my engagement with the PhD project.

12.2.1 Reflexivity prior to commencing the PhD

Based on my personal belief and professional encounters as discussed earlier in Chapter One, there was a continuous reflexive process that had inspired me throughout my professional endeavours. When I reflect upon my aims and aspiration for this PhD project, I can clearly establish that spirituality was always linked to my professional quest.

12.2.2 Reflexive considerations during the study

Throughout my research study I have received extensive support from my supervisory team. Regular meetings were held where the key discussion areas were research planning, progress monitoring and further training needs, at each stage of my PhD journey. I found the process of supervision engaging and it prompted self-directed learning. It helped me to narrow down my ideas to specific issues to be explored further and encouraged me to regularly question my rationale for decision making at various stages of my studies. Polit and Beck (2014) explained the importance of external validation involved with the process of peer review and debriefing that contributes to enhancing the rigour and quality of research. This was particularly relevant during the process of data collection and data analysis.

As discussed in Chapter Four (4.2.1), that there were issues in seeking access to potential universities. The recruitment process required extensive strategic planning with follow up deadlines. Due to the limitation of time and access constraints on the availability of nursing students because of their clinical schedules, exams or teaching timetables; I was constantly communicating with the programme heads and coordinators to plan participants' recruitment. These endeavours allowed me to establish professional networking across universities, developed my confidence and art of adaptability. Also, I learnt the skill of presenting ideas through oral and written communication for an effective project management (Brewer, 2000; Ormston et al., 2014).

A detailed audit trail on each individual case study was recommended to gather evidence and report findings on each case study (Yin, 2009; Robson & McCartan, 2016). Keeping an audit trail and daily logs in the form of a diary enables a researcher to establish internal and external validity of findings in a case study (Robson & McCartan, 2016). I kept the audit trail of all my efforts and professional encounters; including email correspondence, and face-to-face meeting logs with the academic and administrative staff from potential universities. For example, during recruitment phase at UA I recorded that:

I am so impressed that so much faculty support is there from UA. Educators and school administrators are assuring me of more participant involvement, as I can see email invites from the management and educators across year 3 undergraduates nursing programme. Some

educators have spoken about my study in their tutorial groups. However, I have heard from only two year 3 students so far, those were interested to attend the focus group study. I am planning to meet another group of students next week, probably it will work best if I can inspire some students by giving a small presentation during the teaching week. (Personal Memo 05/ UA- Feb 2014)

However, despite the support from educators and programme leaders; it took a long time to recruit adequate number of students for a focus group at UA.

It been almost a year now, I am still waiting to arrange a focus group study at UA. Due to clinical placements, students who committed earlier for the study; had declined. After September, there will be new cohort and seems like I have to plan and recruit more students from the new cohort. This means more time to schedule recruitment by sending email invites, reminders to the programme administer and course leaders for their support. I need to seek permission again for class room presentations from the class tutors (Personal Memo 08/ UA- Aug 2014).

After conducting the focus group study with student nurses at UA, I tried to link the findings with the data gathered from some of the educators as well. I did not establish a formal template at that point to perform the data triangulation. A diary note helped me remember similar ideas and concerns raised during the interviews (King & Brooks, 2017). As I recorded:

Today I met the students, finally got the data from students through Focus group study. I found few students shared some similar points as one educator mentioned in her interview last week. It's interesting to see how student and educator approach and define spirituality linking it with sexuality. I was unclear about how sexuality could be placed or spirituality would be articulated with sexuality but I am thrilled by exploring the roots of human sexuality in autonomy, choices, freedom and actualising potentials; which are very much connecting one- self to his /her inner self and that's all spirituality is all about. (Diary entry UA- Nov 2014)

As discussed in Chapter Four (4.2.5.3.1); while I was doing the data analysis, these reflections, personal memos, audit trails from supervisory feedbacks and diary notes enabled me to explore any

matching patterns to perform data triangulation and establish the internal validity of each case study (Robson & McCartan 2016).

My experience in accessing and recruiting participants for each case study was different. As discussed in Chapter Four (4.2.2.1), based on institutional priorities and research interests; this study received a variety of responses. These included delays in responding to the initial invitation, requests to resubmit the ethics application to potential university ethics committee along with a detailed literature review and a declined response from one university. However, as discussed in Chapter Four (4.2.6), difficulty in accessing and recruiting participants can be a challenge in any research. Flexibility in scheduling the time frame around the potential data collection activities and adaptability in the modes of data collection were found to be effective strategies to address such challenges (Robson & McCartan, 2016).

I recorded my reflection at UB as:

It has been so long that I have applied for ethics approval to UB, but again they have asked me more literature review. This may delay student recruitment but of course will bring more clarity on my research proposal. I will make sure to submit the revised ethics application in a week's time to avoid further delay. I need to plan student focus group study in May, before they go for their clinical placements. (Personal Memo-02/UB)

Through careful planning and keeping a time track by developing a Gantt chart and performing the follow up for ethics clearance, I managed to access the participants at UB (Robson & McCartan, 2016).

It was a fascinating experience to conduct the focus group studies at different universities. As discussed in Chapter Four (4.2.3.3), each student group had their own power dynamics while engaging in discussion with one another. However, I did not experience any challenging behaviours or distressing situations at all. When I conducted the focus group study at UB I reflected:

Today I met the students at UB. I felt so confident about my study, while engaging with relatively big group then UA. I found a sense of fulfilment after this focus group study as students highly acknowledged the need to integrate spiritual care in nursing. I was fascinated as some students

raised similar concerns, I had experienced in my student and professional life as a nurse. This experience validated my quest to bring transformation in existing care standards.

(Diary entry UB- May 2015)

It boosted my confidence and passion to inquire more about the challenges and issues faced by the student nurses, as some to the findings from the focus group study resonated with my previous experiences at as student nurse. This could have led to a personal bias; while I was doing the data analysis. However, as discussed in Chapter Three (3.3.5) and Chapter Four (4.2.5.3), I adhered to the validity and reliability measures while conducting and analysing data (Yin 2009, 2014; Robson & McCartan 2016; King & Brooks, 2017).

My experience at UB (Chapter Six), was different from other case studies in other regards too. Initially I thought, my interaction with nursing educators was not that productive, as I could not get the complete answers from the recruited professional course leads, as discussed earlier (Chapter Six, 6.3.2.1). Due to the flexible learning environment; accessing educators who were involved in direct class room or clinical teaching was impossible. However, when I reflected, I realised that educators at UB, brought a different perspective to nursing education, which I was totally unaware of. Thus, looking back the data once again, I could see that those responses were a finding that could open more avenues to explore different modes of nursing education. Hence, the process of reflexivity enabled me avoid potential biases and assumptions that might impact the findings and their quality (Yin, 2014; Robson & McCartan, 2016).

My experience with UC (Chapter Seven), as a third case study was exceptionally motivational as compared to UA and UB. As discussed in Chapter Four (4.2.3), based on institutional interest, this research study got great support and recognition among course leaders, educators and student nurses. I logged my personal memo as:

I contacted the programme director through social media, and am so excited to hear her positive response. I am shocked and happy both as such an active and prompt response is totally opposite to my previous experiences so far in last two years. I am looking forward to schedule

face-to-face and skype interviews as some of the educators are away these days. (Personal Memo 02/UC- Nov 2015)

Due to the limited time frame of this research study and work load pressures on the educators; educators at UC agreed to Skype interviews only. As discussed in Chapter Four (4.2.3.2), Skype interviews are considered reliable data sources to conduct interviews as it allows face-to-face contact online and saves time for travelling and other arrangements required for face-to-face interviews (King & Brooks, 2017). Conducting Skype interviews as well as recording them on another digital recorder and assuring the voice quality and clarity was a challenge. For this reason, I rehearsed the process of recording a Skype call, prior to the actual interview. I was efficient in collecting data through Skype interviews and learnt technical adoptability to collect data (Robson & McCartan, 2016).

My focus group study at UC went really well. I found students eager to share and learn more about my study. They showed interest in spirituality and shared their ideas from personal and professional experiences. I recorded:

There were four students but they had different experiences and unique stories to share to the group. One student disclosed his atheistic ideology and related spirituality with positive psychology. To him spirituality was all about chaplaincy care and nurses have altogether different health related priorities. His views were however, argued and debated more with his other colleagues. (Diary entry- Feb 2016)

It was interesting to see how spirituality was perceived by an atheist student and how spirituality was debated from different religious orientations with the same group of students at UC. In previous focus group studies at UA and UB, no student shared their view as an atheist, though multicultural and different religious affiliations were mentioned.

Also, due to the limited availability of the booked classroom, I had to conduct the focus group study (with the same students) in another classroom. Another classroom was already booked by the course leader, anticipating more time and discussion may be required for the focus group study (Robson & McCartan, 2016). I was particularly delighted to see the commitment and interest of students towards

the focus group study, as all stayed back and continued discussion in the different class room after a short break, while I did the sitting and recording arrangements (Robson & McCartan, 2016). Students were adaptable with the change of environment and keen to discuss more about the study and research prospects.

My experience with UD was the most awaited among the all five cases. As I recorded:

I contacted UD during autumn 2015 initially, students were away due to clinical. I met the students in Dec 2015 and gave a small talk to introduce my research to them. I haven't heard any response from the students yet. Administrators have advised to contact in early 2016 to check availability of students and educators. So far only one interview scheduled in Jan 2016 with an educator. (Personal Memo/UD- Jan 2016)

Despite constant email correspondence with course leaders and administrators to send the reminders to educators and students; a very disappointing response was received by UD. Only one student and an educator agreed to participate in the study. The educator shared curriculum documents used in UD and promised that she would encourage other colleagues to be part of the study, however, there was not any response from any other educators at UD. Nor, were the educators available for a skype interview.

From students, I received a tentative availability to be part of the focus group study. As recorded:

One student from UD emailed me that she is interested in the research. She informed that herself and another colleague in her class may be available in March 2016, once there are less busy with the assignments. (Diary entry/UD Feb 2016)

With 1-2 students, with tentative availabilities and with a delayed schedule in March or April 2016, it was not feasible to continue owing to the pre-set, time limitations of this study. Already, I was in my final year and could not extend the data collection period, hence I had to drop UD from the main data analysis. Time constraints and environmental feasibility could become a limitation in accessing and recruiting participants, as discussed in Chapter Four. However, acknowledging the richness of data

gathered from three complete case studies, I was still able to perform rigorous data analysis and present robust findings on this research (Yin 2009; Robson & McCartan, 2016).

Similar to the other four universities, it took a lot of effort and time to get ethics clearance and in developing initial correspondence with course leaders and administrators for UE, as discussed in Chapter Four. Despite of all measures to gain access, no response was received from nursing educators at UE. Students responded to the email invitations sent by their course leaders, however, only two students turned up for the focus group study on a mutually agreed date and time, for the study. I recorded:

Ethical approval has been sought. I have got emails from the programme director assuring that email invites would be sent to all educators and students. However, I have not got any response from nursing educators from Oct 2015- Feb 2016. A few students had agreed to participate in focus group study which was scheduled in Feb 2016. It went well but the case study remains incomplete. No participation from nursing educators nor any access to nursing curriculum. I wonder why no response or interest was shown by the teaching staff? Perhaps the study is not their priority or they may have underlying issues in approaching the topic itself? May be an area to explore what makes a university to participate in research studies?

(Diary entry- UD/Feb 2016)

These logs, diary entries and memos helped me to do the required follow up in the next semester if students were busy during the term time. During data collection, the relevant field notes, personal memos, diary entries based on the encounters with the research participants, including student's responses and educators' support facilitated in contextualising findings, avoiding bias and developing objectivity during the process of data analysis (Brewer, 2000; Green & Thorogood, 2013).

12.2.3 Reflexivity During Data analysis:

As discussed in Chapter Four (4.2.5), a template analysis approach (King & Brooks, 2017) was used for data analysis. Template analysis allows reflexivity in several ways. The process allows the development of *a priori* themes to design an initial template for the analysis, which may or may not be

useful in the final template. The critical engagement in developing and revising the template through several iterations, enabled me to recognise the emerging themes, evolving patterns, and, as I analysed each case, to recognise similar and contrasting findings. This enabled me to critically analyse the data when examining the evidence for internal and external validity and performing the reliability checks (Chapter Three, 3.3.5; Chapter Four, 4.3.1 and 4.3.2).

Peer review and supervisory validation are also essential to assure the credibility of template development and technique used for the data analysis. Hence, from *a priori* themes to final template development, critical feedback from the supervisory team was incorporated to reduce any potential bias and maintain quality control (Yin 2014; Robson & McCartan, 2016; King & Brooks, 2017). After performing template analysis on single case studies, (Chapter Five-Nine), a cross-case synthesis combining all the similar and contrasting data was further developed in Chapter Ten. This analysis based on reflexivity and critical examination helped establish the credibility of the findings by presenting theoretical and literal replications across all case studies (Yin 2009, 2014).

Findings based on the data analysis were shared at various seminars, at different universities to seek critical review from different perspectives. A detailed specification of each conference presentation and seminar talk is provided in the beginning of this thesis. Such, experience allowed me to establish the credibility of findings by engaging in critical arguments with multidisciplinary research professionals with diverse opinions. Also, it developed confidence and clarity in identifying potential gaps that could enrich the discussion by relating the literature to the research findings (Robson & McCartan 2016; King & Brooks, 2017)

12.2.4 Reflexivity after data analysis

After data analysis, as discussed in Chapter Three, following Yin's (2014) case study design to establish the reliability of data, research findings were linked to the literature review and propositions set for the research study. Chapter Eleven (11.2.1), presents the details of this. By developing a grid based on the literature review and findings from the template analysis, the convergence of ideas established pattern matching with the literature review (Appendix 11).

Linking research findings with the literature review (Chapter Two), also enabled me to focus more upon the knowledge and practice gaps and influencing factors that affect the integration of spirituality

in nursing education, as argued in Chapter Eleven (11.3.2-11.3.4). Hence, through the process of critical analysis and knowledge synthesis, I was able to develop SOPHIE (11.3.5). SOPHIE as discussed in Chapter Eleven, is a framework for teaching and learning to develop a shared understanding among nursing students, educators and health professionals in general. Hence, creative engagement and reflective account from the research was used to construct new knowledge (Yin, 2014). The process of knowledge production through reflexivity is explained as,

The process through which researchers are conscious of and reflective about the ways in which their question methods and very own subject position might impact on the psychological knowledge produced in a research study (Langdrige, 2007, p. 58-59)

As a research output, SOPHIE was also shared with multidisciplinary forums and seminars. The details of those seminars and steering committee meetings are mentioned in the beginning of this thesis. Presenting research findings allowed me share knowledge base with the wider academia. Also, it enabled me to explore potential avenues to implement SOPHIE, both in nursing education and health practice after the successful completion of my PhD.

12.2.5 Personal transformation and learning

After finishing the thesis, I can now establish how spirituality was always linked to my quest to expand the meaning of care, as discussed in Chapter One. Perhaps it was all vocational. Through undertaking this research study, I am now in a better position to understand human behavioural responses towards loss and hope, the role of a belief pattern, and importance of developing self-efficacy through self-awareness. I can relate spirituality to my personal and professional life with more conviction and belief in therapeutic care.

Through this research journey, I found myself developing in both personal and professional capacities. Initially, I was struggling to differentiate existential concepts from spirituality because of my religious values and beliefs where faith, intellect and spirituality are regarded as part of a unitary phenomenon, the nature of our 'being'. However, over the passage of time and after doing an extensive literature review, I am now increasingly aware of the need to keep clear the distinctions between overlapping domains like spiritual and existential. Also, I found that concepts at the heart of

many definitions of spirituality, such as hope and meaning are common to both domains and can be found in secular as well as religious world-views. Based on my personal belief system, I still regard spirituality as an expanded concept experienced in every aspect of actualising the meaning of existence. To me it is the way of living that includes perception, thinking and reacting to a given situation, hence to me, spirituality is all about self-awareness. I had a narrow perception about spirituality before, entangled with religiosity only. But now, to me spirituality cannot be confined to any particular set of beliefs, feelings or behaviours, rather I see spirituality as an empowerment that connects fragmented thoughts, feeling and actions through intentionality.

I see this evolution not just as an intellectual achievement but perhaps personally whatever happened in my personal life during this study; I can completely relate myself in seeking spiritual care and existential support to become more resilient, authentic and hopeful!

The journey of my PhD studies was not that simple as compared to my previous academic experiences and achievements. As a full-time, international student, there were several challenges I was juggling with throughout these years. These included; regular traveling to the university, anxieties related to academic progression, health issues, financial constraints, and childcare problems due to family breakdown. But I managed it well through strong determination and striving for a healthy balance in all facets of life without compromising one for another. In 2013, I enrolled for the doctoral studies. During the initial months of the research study, I was living locally. Hence, I was able to manage my studies with personal issues, much competently. However, due to personal reasons, I had to move out of Yorkshire to London. Commuting from London to Huddersfield on a regular basis was a huge challenge. But, with strategic thinking and forward planning, I managed it successfully without a failure at any point. During data collection, there were some shortcomings and several limitations in accessing and recruiting the participants as discussed in in Chapter Four. The study could have been more robust if it had been possible to achieve a more timely and comprehensive response from the various Universities approached. However, within the spirit of professional development, that waiting time was also utilised very constructively. I was always encouraged and supported by my supervisors to engage in scholarly activities during the prolonged data collection phase. Various research outputs were communicated through conference presentations and refereed

publications during this period and more are planned for later, which are listed in the beginning of this thesis.

Also, there were inconsistencies in relation to my visa status, changes in the supervisory team and problems related to the timely completion of the study due to personal and professional issues as well as the difficulties in recruitment discussed above. However, when I reflect on all those academic and professional challenges, I feel confident that I managed them competently.

As an international research student, English is my second language. Hence, conveying findings and expressing views in a non-native language (especially when writing) was a barrier to some extent. My supervisors' timely support and constructive feedback facilitated me in developing more articulation in thinking and expressing ideas in academic English writing. Also, I enrolled myself for several in-house trainings sessions to develop academic writing skills.

I can recognise my inner strength and power of my own spirituality that enabled me to be positive and consistent in all my efforts. To me spirituality cannot be confined to any particular set of beliefs, feelings or behaviours, rather I see spirituality as an empowering force that connects fragmented thoughts, feeling and actions through intentionality. To me spirituality is the liberation from fears, inhibitions, guilt and resentments.

I also learnt that, spiritual care needs are the - personal quests that often get manifested through existential pain and search for meaning in life. Hence, any form of underlying crises which leads to self-pity, shame, or loss; actually, yearns for peace and fulfilment. Thus, detachment from conflicting ego states and accepting one-self through knowledge and compassion could be recognised as spiritual care.

It was a positive experience for me when I developed the SOPHIE framework as a response to my personal and professional quest. I hope that SOPHIE will be useful to health professionals and educators to overcome that emptiness which often hinders healing and wellbeing. I wish and pray for continuing this academic exploration with professional endeavours as post-doctoral project.

12.3 Chapter Summary

By explaining the process of reflexivity this chapter has identified how the validity and reliability of this research has been established, throughout the study. This chapter provides evidence in the form of reflective log, audit trails and diary entries which are considered essential tools and measures to avoid potential bias in qualitative research study. Hence, by providing various reference from previous chapters, this chapter authenticates the credibility of the research finding. Also, I have provided a reflective account of my personal learning and professional growth through this research project.

Chapter Thirteen- Conclusion

13.1 Introduction

To conclude the thesis, this chapter revisits key findings and provides recommendations for further improvements in nursing education. It also acknowledges the challenges faced during this study and the limitations of the study. In the light of this it discusses future research prospects. Finally, this chapter presents a reflection on personal growth and learning transformation during the entire journey of PhD studies.

13.2 Summary of the research findings

1. An explicit recognition and adequate integration of spirituality is required in undergraduate nursing education to develop a shared understanding among students and nursing educators.
2. Integrating spirituality in undergraduate nursing education calls for more clarity both in classroom teaching and during clinical experience. Lack of clarity and confusion in relating spirituality to nursing education, may result in avoidance or dealing with spiritual care needs as an implicit element of holistic care.
3. 1:1 mentorship, and reflective activities are recommended to overcome the challenge of confidence and engagement associated with the fear and question of authority among student. In this way mentors are able to present and interpret reality for the student
4. The present healthcare culture focuses on technical nursing education rather than interpersonal and existential aspects of care of nursing education. Hence, spiritual care is largely influenced by care priorities shaped by personal experiences, confidence level, personal interest, time and environmental factors, which limits the holistic aspect of person-centred care.
5. Spiritual care is neglected in nurse education partly owing to confusion between religion and spirituality. An underlying fear of 'getting it wrong' and possibly causing offence to others in a multicultural society also contributes.

6. Anxiety related to personal belief and role confusion with chaplaincy services often results in an inadequate representation of spirituality in nursing education.
7. The existing nursing curriculum with a modular and choice-based approach may lead to an inadequate representation of spirituality in both classroom and practical education.
8. It is important to recognise students and nursing educators' spiritual care needs to authenticate their professional roles. Self-awareness is essential to develop acceptance and compassion for self and others. SOPHIE could be useful as a reflexive framework to embrace spirituality in nursing education and practice.

13.3 Recommendations

Despite many educational and clinical tools developed by nursing scholars in recent years to assess spiritual care needs and prepare competent learning structures (McSherry et al., 2002; Wallace et al., 2008; Nardi et al., 2011; Tiew & Creedy 2012; Tiew et al., 2013), a very choice-based and personalised approach was found amongst nursing educators. The importance of spirituality needs to be recognised by the standard setting and curriculum development authorities to establish its application as an essentially required element of teaching and learning.

Conceptual clarity about spiritual care needs to be established with an educational framework and explicit recognition of spiritual care in required standards. This would facilitate a shift from a task-focused mechanical approach to nursing to a truly holistic and person-centred approach which gave equal importance to spiritual care. Due to a focus on narrowly-defined 'evidence-based' practice, care practices often appear to be mechanical representations of the health 'industry' (Francis, 2013). An emphasis on spiritual care could help restore the balance between technical care and the healing aspects of interpersonal care. Integration of social humanities courses such as philosophy, phenomenology, anthropology and art could be a way of developing these competencies in students (Callister, et al. 2004; Kenny & Ashley 2005; Benner, et al., 2010; Yuan & Porr, 2014; Bennett & Thompson, 2015). More research is needed into whether and how these and other approaches can be incorporated into an already crowded nursing curriculum. What is clear is that humanity and spirituality should not be overlooked in favour of a purely mechanistic and dualistic approach to care. More research is required into how to overcome the underlying socio-political barriers to promote an

enabling environment that can facilitate more person to person engagement and transformation in health care.

This research has recognised deficiencies in the existing nursing curriculum with its relative neglect of the ontological aspects of becoming and being a nurse embedded in the modular and choice-based approach, that has resulted in inadequate representation, lack of preparedness, role confusion and practice ambiguity. A standardised guide with a theme summary and potential sub-themes could be provided to educators with a resource pack. A cross-disciplinary approach could be integrated with nursing courses to widen the students' perspectives on health and wellbeing. A framework, SOPHIE has been developed as a response to the findings of this study in the context of the wider educational literature. This addresses the issues identified through this research, especially the need for teaching and learning methods that support the personal and professional development of nurses as self-determined individuals with a strong emphasis on holistic, person-centred care that embraces spirituality and counters a more mechanistic approach to care. It could be used as a reflective framework for teaching and mentoring. Using the heutagogical learning approaches, SOPHIE could engage nursing educators and student nurses in exploring their own spiritual care needs. Such reflexivity may facilitate students in approaching spiritual care needs of their patients during clinical care. Further research is recommended to assess its utility and generalisability.

13.4 Dissemination strategy

After passing the examination, this thesis will be available publicly via the university of Huddersfield repository. Contributions in national and international conferences and publications in refereed journals and book chapters is part of dissemination strategy (Green & Thorogood, 2013; Robson & McCartan, 2016).

13.4 Future Research prospects

More research is required on how to develop authenticity and congruency in professional roles for both student nurses and educators. Understanding and acknowledging spiritual care needs of student nurses and educators through 1:1 reflection, mentorship and peer support may enable transformation and confidence to recognise spiritual care needs in others. The Scope of SOPHIE in both teaching

and practice could be explored with further investigation into self-transformation and empowerment. More studies on the implications of the hidden curriculum in health education, could also be planned to overcome the knowledge and practice gap in nursing education.

13.5 Limitations

More cases might have produced additional findings, however, given the time involved in identifying and gaining co-operation from cases; it would have been difficult to fit a larger number of cases into the time available for completion of the PhD. Being a self-funding research student, the time frame that may have allowed to conduct more case studies, could not be extended. As mentioned in Chapter Four there were delays in accessing and recruiting research participants. However, due to financial implications and a limited international visa for the study, only three case studies as complete single case studies, were considered for the cross-case synthesis (Chapter Ten). Also, being a novice researcher, performing a case study for the first time, at different geographical locations and institutional contexts across England; was a huge challenge. However, I was extensively reflexive and critical, to avoid any potential biases that might impact the findings of this study.

13.6 Chapter Summary

This chapter has presented the summary of all key findings based on the research study. Also, it has provided recommendations to expand the scope of integrating spirituality in education by reconceptualising institutional policies and curriculum focus on ontological and transformative learning approaches. Rather than a purely task-based mechanical approach to care, this study seeks to find ways to embed a wider approach to nursing education that values holistic person-centred care embracing the importance of ontological development and spiritual sensitivity. Several dissemination strategies have been discussed to ensure the findings are more widely known and promote possible approaches to integrating spirituality in nursing education. Future research avenues were identified to further explore the research findings; especially with reference to the impact analysis of SOPHIE, as a framework to address existing the knowledge and practice gap in nursing education. After mentioning about the underlying limitations that may have impacted the study; this chapter has concluded the thesis.

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Appendices

Appendix 1: Summary of Literature review (1993-2017)

Year/ Author	Purpose of the study	Type of study/ Information	Findings, strengths and limitations
1993 Narayanasamy	The need of preparing nurses on adequate educational grounds to address spiritual care needs of their patients was established	A small survey study	The study highlighted that nurses do acknowledge patients' spiritual needs but find lack in confidence to address spiritual care needs. <u>Theme:</u> Teaching and learning approaches
1994 Ross	Need analysis to train nurses for spiritual care competency	Expert opinion	Emphasised on exploring how and what to be taught to nurses to be competent in spiritual care. <u>Theme:</u> Teaching and learning approaches
1997 Bradshaw	Need analysis on preparing nurses for spiritually competent care.	Expert opinion	Argues whether spirituality can be taught to students or spirituality is personal and vocational. <u>Theme:</u> Teaching and learning approaches
1997 McSherry and Draper	To explore how to integrate spirituality in nursing education and practice.	Expert Opinion	Explored factors shaping the role and status of nursing in society and influencing the institutional inclinations to integrate spiritual factors. <u>Theme:</u> Conceptual analysis of the term spirituality.
1999 Bush	Journaling as a tool to develop understanding of spirituality	Reflective Paper	Applied theoretical knowledge and principles but no research method was used to measure the effectiveness of the intervention. <u>Theme:</u> Teaching and learning Approaches
1999a Narayanasamy	Proposed "ASSET" Model linking self-awareness to recognition of spiritual factors	Expert opinion	This model was recognised and used by Baldacchino (2008, 2010) in developing study units for undergraduate and graduate nurses. <u>Theme:</u> Nursing Model on Spiritual care
1999 Greenstreet	Explored the concept of spirituality in nursing education	Literature Review from 1970- 1999	Identified challenges to teaching spirituality in nursing. Limited exploration of how concepts of spirituality were embedded in nursing curriculum. Lacked student perspectives. Did not explore pedagogical issues.

			<p><u>Theme:</u></p> <p>Conceptual analysis of the term spirituality</p>
2000 McSherry	Explored debates surrounding teaching of spirituality in nursing education.	Expert Opinion	<p>Presented a critical analysis of both historical and traditional teaching and learning approaches to integrate spirituality in nursing education.</p> <p>Did not consider philosophical and transcultural issues adequately.</p> <p><u>Theme:</u></p> <p>Teaching and learning approaches</p>
2002 McSherry, et al.	Developed spirituality and spiritual care rating scale (SSCRS), to determine the effectiveness of integrating spirituality in the nursing curriculum.	SSCRS (17 item Likert scale)	<p>Validity and reliability tested.</p> <p>Lovanio and Wallace (2007), Wallace et al. (2008), and Tiew et al. (2013) found this scale effective understanding students' needs and reflections whilst integrating spirituality in nursing education.</p> <p><u>Theme:</u></p> <p>Quantitative Approaches</p>
2002 Pesut	To explore how undergraduate nursing students, perceive spirituality and spiritual health and relate it to spiritual care.	An exploratory study.	<p>The study was conducted in a private Christian nursing institution; the study was strongly influenced by Christian theology and of limited application in a multi-cultural setting.</p> <p>The validity of 20 item scales used to assess quality of spiritual health was not established.</p> <p><u>Theme:</u></p> <p>Teaching and learning Approaches</p>
2002 Hoover	To evaluate the impact of a module on caring based on Watson's transpersonal caring-healing model (1999), with significant emphasis on spirituality.	Focus group interviews taken from 25 students, before and after the course implementation.	<p>The study finding demonstrated an increase in self-awareness, finding meaning in connecting with self and others, value clarification and increased knowledge about holistic care. However, the study lacks in recommending potential courses to be integrated in nursing curriculum to put due emphasis on spiritual care aspects while recognising compassionate care as an expression of integrating spirituality in nursing education.</p> <p><u>Theme:</u></p> <p>Teaching and learning approaches</p>

2004 Callister, L. C., et al		Survey from 132 BScN students in USA.	<p>Students views on the integration of spirituality in nursing education was gathered. Curriculum review presenting different courses and integration of spirituality in one of US college of nursing was presented.</p> <p>Detailed account of teaching and learning strategies used by only one college was presented as an exemplary case.</p> <p>This study could be useful to develop integrated nursing curriculum as several course structures were shared. Further researches would be required to confirm its validity and application.</p> <p><u>Theme:</u></p> <p>Nursing Curriculum</p>
2005 Kenny & Ashley	To recognise the need of a specialised course for integrating spirituality in paediatric nursing education. The results showed that some of the challenges of delivering spirituality are common to both adult and children's nursing.	A Questioner was developed	<p>Specialised curriculum is recommended to address spiritual care needs of children and their family. A valuable contribution exploring students' perspectives and needs to bring innovation in existing UK undergraduate curriculum.</p> <p>Validity of questioner developed is questionable as well. A small student sample from one UK university, more researches in this aspect could inform the needs and perspectives.</p> <p><u>Theme:</u></p> <p>Nursing Curriculum</p>
2007 Mooney and Timmins	To teach and incorporate spiritual concepts in an innovative way.	Focus group study	<p>Along with class room teaching activity, nursing students were taken out on a museum visit to engage in a reflective activity to comprehend spiritual aspects through the medium of creative Art. The article gives little description of the nature of spiritual themes covered in the teaching sessions prior to the museum visit. The underlying philosophical structures anchoring the teaching marked this study as a significant step in approaching spirituality from a phenomenological perspective.</p> <p><u>Theme:</u></p> <p>Teaching and learning approaches</p>

2008 Wallace et al.	The purpose of this project was to integrate spirituality into the undergraduate nursing curricula and measure student outcomes related to spiritual knowledge and attitudes.	A quantitative, (pre-test/post-test) and qualitative study based on SSCRS (McSherry <i>et al.</i> , 2002)	<p>Significant differences in spirituality knowledge and attitudes among senior-level nursing students observed. Hence, study recommends that, A) concept of spirituality should be threaded throughout the curriculum, from the first to the final year courses. B) Nursing educator should be encouraged and supported for taking specialised workshops on understanding and approaching spiritual ideas. C) Transcultural studies, world religion, and courses on diverse value beliefs should be integrated within nursing education.</p> <p>A well-structured study, however, briefly discusses the curriculum innovation to suggest a way forward.</p> <p><u>Theme:</u></p> <p>Quantitative approaches/ Teaching and learning Approaches</p>
2008 McSherry, et al.	To explore the ethical basis of teaching student nurses about the concepts of spirituality and spiritual care.	Exploratory longitudinal design. Progressing students from year 01- year 03 undergraduate programme. A questionnaire incorporating the Spirituality and Spiritual Care Rating Scale used.	<p>Response rate of 76.7% was achieved on the SSCRS. Spirituality was majorly perceived as related with existential phenomenon of human life. Several uncertainties and anxieties were reported by students on inquiring whether spirituality could be taught.</p> <p>The study findings cannot be generalised due to limited cohort size and sampling. Students perspectives gathered by qualitative exploration are required to study the nature of issues for further proposals.</p> <p><u>Theme:</u></p> <p>Students' perspectives</p>
2008 Baldacchino	To develop awareness of spirituality in students to facilitate spiritual care.	Study unit developed.	<p>A study unit on the spiritual dimension in care was designed and introduced but not fully evaluated. Course content could be a useful re- source for developing future module on spirituality and holistic care.</p> <p><u>Theme:</u></p> <p>Teaching and Learning Approaches</p>
2008 van Leeuwen et al.	To study the effect of a course for nursing students on developing competence in spiritual care.	Quasi-experimental crossover design (pre–post-test). The Spiritual Care Competence Scale, Cronbach's alpha	<p>Student groups (Control and intervention) were found confident and improved in spiritual care proficiency. The study has the strengths of quantitative design in measuring change and difference in assessing student's spiritual care competency, but students' self-perceived</p>

		0.82, (van Leeuwen et al. 2007) was used	competencies could be argued based on same religious background. <u>Theme:</u> Quantitative Approaches
2009 Taylor et al.	To study how attitudes toward spiritual care, changed from before to after, a self-study programme on spirituality.	201 nursing students and RNs, independently completed the mailed self-study programme Study was evaluated on the basis of self-report study instruments (i.e. Daily Spiritual Experience Scale, Spiritual Care Perspective Scale-Revised, Response Empathy Scale, Communicating for Spiritual Care Test, and Participant form.	A pre-test and post-test, pre-experimental design was used to study attitudinal shift toward spiritual care, ability to create empathic verbal responses after going through the self-study programme. The finding suggests that to an extent the self-study programme was useful for both student and graduate nurses in developing understanding about their own spirituality and understanding the spiritual care needs of their patients. However, the validity and transferability of such a self-study programme could be challenged in terms of human touch over virtual grounds to teach and explore spirituality and spiritual care needs in nursing. <u>Theme:</u> Teaching and Learning Approaches.
2011 Nardi, Faan and Rooda	To develop a practice theory of spirituality based nursing to teach integrating metaphysical and spiritual appropriation in nursing care.	Exploratory mixed-method study. A comprehensive review of current textbooks, published papers, and research on holistic nursing and spirituality, 45 statements on personal spirituality converted to Likert scale questionnaire.	A practice theory was developed to teach spiritual and metaphysical aspects of nursing care. However, this study does not adequately address the existing curriculum needs with reference to knowledge and practice gaps, to integrate metaphysical and spiritual care approach in nursing students. <u>Theme:</u> -Conceptual analysis of the term spirituality -Teaching and Learning Approaches
2012 Barss	Describes the development of "TRUST" model for understanding spiritual care needs of patients.	Expert Opinion	Limited competencies were mentioned with reference to nursing educators to enable self - evaluation or continuous self-transformation as a major teaching and learning component in nursing education. No further research validating the impact of the TRUST model

			<p>found.</p> <p><u>Theme:</u></p> <p>Teaching and Learning Approaches. Nursing Model</p>
2012 Cone and Giske	To study how nurse educators, prepare students to learn to assess and care for spiritual needs.	Grounded theory based on semi-structured interviews with 19 educators	<p>Found role-modelling and mentoring supported students' development of insights concerning spirituality and spiritual care needs.</p> <p>Curriculum issues (facilitators and barriers) not explored.</p> <p><u>Theme:</u></p> <p>Nurse Educators' Perspectives</p>
2012 Giske and Cone	To explore undergraduate nursing students' perspectives on spiritual care and how they learned to assess and provide it.	Grounded theory, Data collected through semi-structured interviews at three Norwegian University Colleges in eight focus groups with 42 undergraduate nursing students.	<p>Students highlighted the need to integrate existential and spiritual components more explicitly in nursing education. Evaluative discussions on clinical interventions and role-modelling by nursing educators were appreciated.</p> <p><u>Theme:</u></p> <p>Nursing Students' perspectives</p>
2012 Giske	To explore how nursing students learned about spiritual concepts in clinical studies.	Literature review (1980-2012)	<p>Only 10 articles were identified over 30 years. The study identified the following factors: learning through real-life clinical experiences; use of specific teaching and learning methods; self-awareness regarding spiritual needs and support from nurse educators.</p> <p><u>Theme:</u></p> <p>Teaching and Learning Approaches</p>
2013 Timmins F Neill F	To evaluate the content and delivery outcomes of teaching spirituality in nursing education.	<p>Literature review 2007-2012.</p> <p>3 papers were examined indicating 2 researches in USA and one in</p>	<p>Approaches found rooted majorly on religiosity factor. Does not provide sufficient studies carried on globally, to generalise the quality and impact of such studies.</p> <p><u>Theme:</u></p> <p>Teaching and Learning approaches</p>

		Malta.	
2013 Cooper K, Chang E, Sheehan A, Johnson A	To explore the impact of spiritual care education on nursing students	Literature review (1993-2011)	<p>The article provides a literature review on how spiritual care aspects are integrated in nursing education (1993-2011). Also, it discusses some studies exploring the perception of nursing student on learning spiritual care components.</p> <p>This study proposes the need of further nursing researches to explore integration and impact of spiritual care education on nursing students in Australia.</p> <p>Lacks conceptual clarity in relating aim and findings.</p> <p>Theme:</p> <p>-Nursing Students' Perceptive</p>
2013 Tiew et al.	To determine the integration of spirituality in curriculum, and effectiveness of a focused student education project	Descriptive cross-sectional study using Spiritual Care Giving Scale SCGS (Tiew and Creedy, 2012)	<p>Could be useful to relate with multi-cultural perspective. Previous UK and USA based similar studies were compared to declare the congruency in findings from Asian perspective. However, the reliability and validity of the newly developed SCGS (Tiew and Creedy, 2012) tool could be challenged.</p> <p>Theme:</p> <p>Nursing Students' perspectives</p>
2014 Lopez et al.	To explore Australian nursing students' perceptions on spirituality	A cross-sectional survey was conducted - A 32-item WHO-QOL-SRPB questionnaire was used.	<p>The study marks that nursing students should understand their own spirituality before approaching patients spiritual care aspects. However, the findings found based on comparing gender, and making judgments on spiritual articulation based on religious affiliations. Hence, leaves this study in very narrow position to validate and generalise the aim of this study.</p> <p>Theme:</p> <p>Nursing Students' Perception</p>
2014 Timmins et al.	To explore the degree of inclusion of spirituality and spiritual care concepts in core nursing textbooks by	Spirituality Textbook Analysis Tool (STAT) developed and	This study identifies that nursing texts should be strengthened by providing consistent focus and inclusion of spiritual care themes.

	going through all nursing and midwifery core books (n= 580). Perceptions of spirituality.	validated.	<u>Theme:</u> Nursing Texts, Documents reviews
2014 Narayanasamy	To emphasis upon the need of integrating spirituality in nursing education as a response to emerging multicultural and diverse religious and cultural needs in UK.	Review article	The paper highlights the ambiguity and discrepancies in governmental policies and structural issues overlooking the issues of ethnic plurality with reference to spiritual care needs of NHS patients. The review calls for integrating spirituality in nursing education by acknowledging the spirit equality and antidiscrimination in the multi-cultural society. <u>Theme:</u> Nursing Curriculum, Teaching and learning approaches.
2014 Yilmaz and Gurler	Explores the efficacy of a revised and integrated undergraduate curriculum compared with a traditional nursing curriculum in Turkey.	A quasi-experimental post-intervention two-group design was conducted from 2009-2011 covering different academic years. A total of 130 students participated.	The intervention group consisting of students exposed to an integrated curriculum, scored significantly better on the SSCRC than a control group, using a traditional nursing curriculum. The study emphasised the need to revise the existing nursing curriculum to integrate spiritual care. This study could be considered as a pioneering step in reconstructing a national nursing curriculum <u>Theme:</u> Nursing Text books and Curriculum
2015 Lewinson, et al.	Identifies various scholarship and clinical approaches developed to related spirituality in undergraduate nursing education.	Literature review (2002-2014)	A comprehensive review on studies done in various parts of the world. Provides inclusive review on both educational and clinical practices developed to integrate spirituality in nursing education. Lacks in approaching spirituality from ontological perspective. <u>Theme:</u> Teaching and Learning approaches
2015 Bennett V., Thompson M.L.	To explore effective teaching strategies for nursing educators to integrate spirituality in nursing education.	Literature review	Several challenges and barriers in teaching spirituality in nursing education are recognised. The paper reviews different teaching and learning strategies that may be useful for developing confidence and preparing nursing educators to relate spiritual care components

			<p>in nursing courses.</p> <p><u>Theme:</u></p> <p>Teaching and Learning approaches</p>
<p>2016 Kalkim et al</p>	<p>To explore student nurse's perspectives on spirituality and spiritual care in Turkey</p>	<p>Descriptive survey using nursing student sociodemographic form, form on nursing students' knowledge and practices of spirituality and spiritual care, and the Spirituality and Spiritual Care Rating Scale.</p>	<p>SSCRS credibility as Turkish version was established. Cronbach's alpha coefficient was 0.76 and the alpha coefficient reported for this study was 0.82. Multiple linear regression analysis identified the impacts of variables. 0.05 was set as the level of significance.</p> <p>Inadequate integration of spirituality in nursing education was reported by nursing students. knowledge and practice gap, time and work constrain along with lack of clarity from nursing educators were identified as major challenges. however, based on personal experiences and belief systems students found addressing and relating to spiritual care needs.</p> <p>The study was conducted using purposive sampling in one school of nursing, hence its generalization and reliability is questionable.</p> <p><u>Theme:</u></p> <p>Knowledge and practice gap, perspectives of student's nurses.</p>
<p>2016 Caldeira S., et al</p>	<p>To explore how spirituality is addressed in undergraduate nursing curricula across Portuguese and Brazilian nursing schools in 2014-2015.</p>	<p>Cross-sectional, descriptive, and survey research, electronic questionnaire sent via email.</p>	<p>129 email responses from nursing educators received. Several curricular units identified encompassing spirituality. However, varied content and teaching approached were used. it was concluded that spirituality is poorly addressed in clinical practice. Although, the importance of teaching spirituality was recognised in undergraduate nursing education, however no standard or established curriculum was found in nursing schools.</p> <p><u>Theme:</u></p> <p>Nursing curriculum, View from Nursing educators.</p>

Appendix 2: School Research Ethics Panel Form

THE UNIVERSITY OF HUDDERSFIELD School of Human and Health Sciences – School Research Ethics Panel

AMENDMENTS TO PROPOSAL

(Attach separate sheets as necessary)

Applicant Name: Gulnar Ali

Title of study: **How is spirituality expressed and addressed in nursing curricula in England?**

Issues	A holistic approach is central to nursing care. This recognizes the importance of spiritual and religious care in promoting health and wellbeing (NANDA 2014, RCN 2011, RCN 2015). However, assessment and care planning do not always take these factors into account. Nor are they always made explicit in standards. In the UK, for example the regulatory body's latest Code of practice does not mention them (NMC, 2015). Though formal recording of religious affiliation is commonly undertaken, the assessment of spiritual needs is rarely recorded. Difficulties persist in conceptualising spiritual needs and understanding their relationship to religious needs and relevance to wellbeing.
Researcher(s) details	Gulnar A Ali
Supervisor details	Dr. Michael Snowden, Prof John Wattis
Aim / objectives	<p>Aim:</p> <p>This study aims to contribute to a better understanding of how nursing competencies in understanding and addressing spiritual needs are currently approached in undergraduate nurse education. On the basis of this improved understanding it may be possible to propose ways of further developing education in this area to address patient need in a more holistic way.</p> <p>Objectives:</p> <ol style="list-style-type: none">1. To analyse how spiritual care aspects are integrated in undergraduate nursing curriculum.2. To identify concerns of nurse educators while approaching spiritual care aspects through teaching practices.

	<p>3. To assess how well prepared current senior nursing students feel to assess and address spiritual care needs in their patients.</p>
Methodology	<p>An instrumental approach using multiple case study design has been chosen to explore the underlying challenges of integrating spiritual care ideas in nursing education. For this study, the “cases” would be each of recruited universities, where an undergraduate nursing programme is offered. A case may reveal variation in programmes offered, diverse perspectives from the stake holders and variety in programme components as the basic framework or philosophy of the course. Hence, for the research, few nursing universities will be studied as multiple cases to inquire about the level of integration, perceived challenges and barriers with reference to spiritual care aspects in undergraduate nursing education. The rationale for considering multiple universities is based on the concept of replication (literal or theoretical).</p> <p>Methods of Data Collection</p> <p>Document Review: Documents reviewed will include NMC requirements in the area of spiritual needs, the curriculum and any modular specifications relating to teaching aspects of spiritual care competencies</p> <p>Interviews: Semi structured in- depth interviews with 3 nursing educators, who are involved in curriculum delivery and development, will be approached to participate in the study</p> <p>Focus groups: Two focus groups of 6-10 undergraduate nursing students will be held at each university (case).</p> <p>Data Analysis: The gathered data will be analysed through a process of thematic coding assisted by the use of NVIVO software.</p>
Permissions for study	<p>Permission Progress from each university is as follows:</p> <ul style="list-style-type: none"> • Permission sought from three universities. • In progress with other universities
Access to participants	<p>Purposeful sampling would be used to select approachable universities with an undergraduate nursing programme.</p> <p>After seeking formal permissions from the official heads/Dean of identified Schools, potential participants would be approached through email contact. Once, the initial permission was granted, the course leader of each undergraduate nursing programme would be approached and asked for their co-operation in accessing the local syllabus, identifying relevant members of</p>

	<p>staff to be interviewed and arranging access to senior student nurses for focus groups all, of course, subject to consent. Potential interviewees will be sent a brief introduction to the project via email and their informed consent and co-operation will be sought. Approaches to senior students will be made through course leaders and their advice will be sought about the best method for approaching students. Those interested in participating will be sent an information sheet, along with a formal consent would be sent via email. The information sheet will include the possibility for a telephone conversation to clarify any issues before any decision to consent is made. Consent will be recorded immediately before each interview or focus group</p>
Confidentiality	<p>The interviews and focus groups will be recorded and anonymised. All information will be treated as confidential and managed according to the University of Huddersfield's data protection standards and would be shared with the supervisory team for further guidance. The only exception would be where ethical or legal obligations would necessitate disclosure to appropriate authorities according to NMC standards and any relevant policies.</p> <p>Identified participants would be informed that the meetings be recorded and transcribed. Recorded data would then be transcribed and stored confidentially and anonymously or in pseudo names identified by the participants themselves, where applicable. All hard copy data would be safely secured in locked cabinet and electronic data would be kept encrypted and password protected, in compliance with data protection standards and guidance of University of Huddersfield and British Educational Research Association (BERA, 2011). All the Policies regarding intellectual property plagiarism, privacy, taking informed consent and disclosure will be followed.</p>
Anonymity	<p>During research all data collected from the participants will be kept secure with full anonymity or with pseudo names identified by participants, if requested. This research may, at some point, be published in a journal or report however, Participants' anonymity will be ensured all the time and Schools will also have their anonymity preserved.</p>
Psychological support for participants	<p>In the unlikely event that the interviews caused distress or health and safety issues, subjects would be offered the possibility of terminating and withdrawing from the project. The partial data gathered would then be discarded or permission would be sought for using any information already gathered. Participants would also be reminded of the support available through their institutions in terms of professional help, if required.</p>

Researcher safety / support (attach complete University Risk Analysis and Management form)	During university working hours, rooms would be booked in respective university premises to conduct interviews acknowledging gender and safety policies of the University of Huddersfield (2011) and according to the guidance of British Educational Research Association (BERA, 2011). Appendix 01
Information sheet	Appendix 02
Consent form	Appendix 03
Letters	Letter of correspondence from Supervisors/ departmental heads are attached. Appendix 04
Questionnaire	Appendix 05
Interview schedule	May - Dec, 2015
Dissemination of results	During the research, all data collected from the participants will be kept secure with full anonymity or with pseudo names identified by participants, if requested. This research may, at some point, be published in a journal or report however, participant's anonymity will be ensured all times, and institutions will also have their anonymity preserved. The only exception would be where ethical or legal obligations would necessitate disclosure to appropriate authorities according to NMC standards and any relevant policies. A copy of the final report will be made available to the appropriate "Head" of nursing at the participating university. Results will be disseminated through conference papers and papers in appropriate nursing or educational journals in addition to forming the basis for doctoral thesis.
Other issues	Not applicable
Where application is to be made to NHS Research Ethics Committee	Not applicable
All documentation has been read by supervisor (where applicable)	YES

Signed: Gulnar Ali _____
(SREP Applicant – electronic signature acceptable)

Date: ____April 13, 2015_____

Appendix 3: Information sheet for Nursing students

Participant Information and Invitation for Student Nurses

Dear Student,

I would like to offer you the opportunity to participate in a research study that explores how spirituality is expressed and addressed within the undergraduate nursing curricula in England. This research is being conducted in Sept 14- Dec 2015 by Gulnar Ali, as part of her doctoral studies at the University of Huddersfield, supervised by Dr Michel Snowden and Professor John Wattis, who would like to invite you to take part; this sheet and the accompanying documentation will give you information to help you decide whether you may wish to become involved in the study.

Thank you for taking the time to read the enclosed information.

Head of the Department, Nursing Studies.
University of xxx, UK

Title of Project**How is spirituality expressed and addressed in nursing curricula in England?**

Information sheet for Nursing Students

You are being invited to take part in this study on how nursing education prepares students to integrate spiritual aspects into holistic care. Before you decide to take part, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with me if you wish. Please do not hesitate to ask if there is anything that is not clear or if you would like more information.

What is the study about?

The purpose of this study is to contribute to a better understanding of how nursing competencies in understanding and addressing spiritual needs are currently approached in undergraduate nurse education. On the basis of this improved understanding it may be possible to propose ways of further developing education in this area to address patient need in a more holistic way.

Why I have been approached?

You have been asked to participate in a focus group with a number of your colleagues because you are a final year nursing student who can inform the researcher about existing challenges in relating spiritual care aspects in nursing education and suggest possible solutions.

Do I have to take part?

It is your decision whether or not you take part. If you decide to take part you will be asked to sign a consent form, and you will be free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you. The partial data would be discarded or permission would be sought for using any information already gathered.

What will I need to do?

If you agree to take part in the research, the researcher will negotiate with you and other potential participants to agree a suitable venue, date and time to conduct a focus group along with other undergraduate nursing students in your university campus. The focus group will probably last in 30-40 min.

Will my identity be disclosed?

All information disclosed within the interview will be kept confidential and identities of both individuals and Schools will be anonymised in reports. The only exception would be where ethical or legal obligations would necessitate disclosure to appropriate authorities according to NMC standards and any relevant policies.

What will happen to the information?

All information collected from you during this research will be kept secure, locked and encrypted. It is intended that the research findings will be published in journal or conference papers but anonymity will be preserved although it may be necessary to quote your words in the presentation of the findings and your permission for this is included in the consent form.

Who can I contact for further information?

If you require any further information about the research, please contact me on:

Name: Gulnar Ali

E-mail: Gulnar.ali@hud.ac.uk

Appendix 4: Information sheet for Nursing Educators

Participant Information and Invitation for Nurse Educators

Dear colleague,

I would like to offer you the opportunity to participate in a research study that explores how spirituality is expressed and addressed within the undergraduate nursing curricula in England. This research is being conducted in Sept 14- Dec 2015 by Gulnar Ali, as part of her doctoral studies at the University of Huddersfield, supervised by Dr Michel Snowden and Professor John Wattis, who would like to invite you to take part; this sheet and the accompanying documentation will give you information to help you decide whether you may wish to become involved in the study.

Thank you for taking the time to read the enclosed information.

Head of the Department, Nursing Studies.
University of xxx, UK

Title of Project**How is spirituality expressed and addressed in nursing curricula in England?**

Information sheet for Nursing Educators

You are being invited to take part in this study on how nursing education prepares students to integrate spiritual aspects into holistic care. Before you decide to take part, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with me if you wish. Please do not hesitate to ask if there is anything that is not clear or if you would like more information.

What is the study about?

The purpose of this study is to contribute to a better understanding of how nursing competencies in understanding and addressing spiritual needs are currently approached in undergraduate nurse education. On the basis of this improved understanding it may be possible to propose ways of further developing education in this area to address patient need in a more holistic way.

Why I have been approached?

You have been asked to participate because you are a nursing educator, who can inform the researcher about existing challenges in relating spiritual care aspects in nursing education and suggest possible solutions.

Do I have to take part?

It is your decision whether or not you take part. If you decide to take part you will be asked to sign a consent form, and you will be free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you. The partial data would be discarded or permission would be sought for using any information already gathered.

What will I need to do?

If you agree to take part in this research, the researcher will AGREE A suitable date, time and venue with you to proceed with a 1:1 semi structured interview which may last for 40 min to an hour. There may be a need for telephone or email follow up to clarify any matters that are unclear but this will be kept to a minimum.

Will my identity be disclosed?

All information disclosed within the interview will be kept confidential and identities of both individuals and Schools will be anonymised in reports. The only exception would be where ethical or legal obligations would necessitate disclosure to appropriate authorities according to NMC standards and any relevant policies.

What will happen to the information?

All information collected from you during this research will be kept secured, locked and encrypted. It is intended that the research findings will be published in journal or conference papers but anonymity will be preserved although it may be necessary to quote your words in the presentation of the findings and your permission for this is included in the consent form.

Who can I contact for further information?

If you require any further information about the research, please contact me on:

Name: Gulnar Ali

E-mail: gulnar.ali@hud.ac.uk

Appendix 5: Presentation on spirituality to invite students

Exploring how spirituality is expressed and addressed in nursing curricula through multiple case studies in England.

Gulnar Ali

University of Huddersfield, UK

Doctoral Student

M.Sc (Medical Anthropology)

M.A (Islamic Studies)

RN (General Nursing)

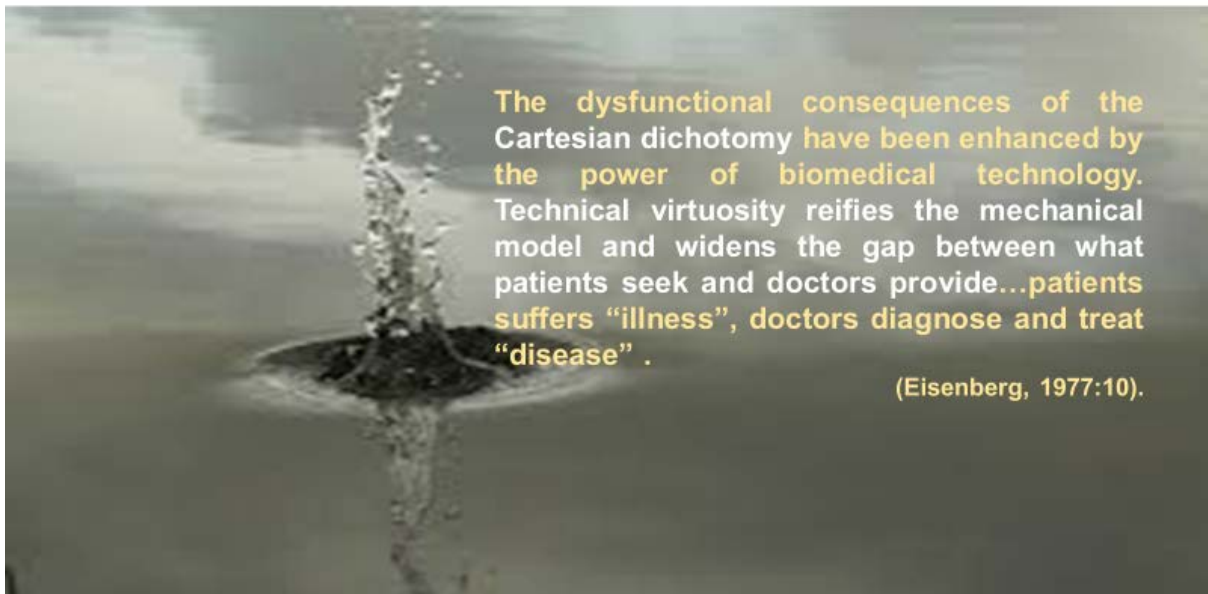
Notion of Being...?

The life of consciousness-cognitive life, the life of desire or perceptual life- is subtended by an “**intentional arc**”, which projects round about us our past, our future, our human settings, our physical, ideological and moral situation, or rather which results from our being situated in all these respects. **It is this intentional arc which brings about the unity of the senses, of intelligence, of sensibility and motility. And it is this which “goes limp” in illness.**

(Merleau-Ponty Cited in Baldwin, 2004:17).



Mind Body Dualism...What is Holistic CARE???



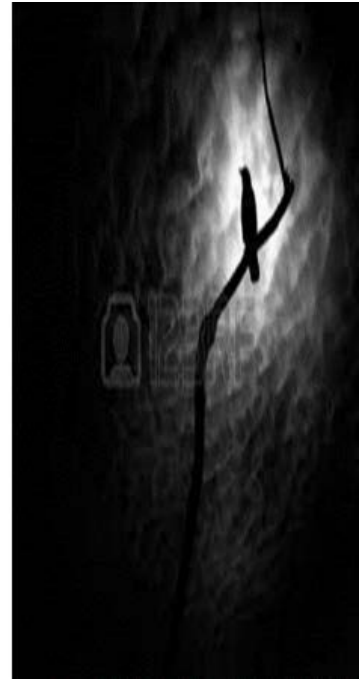
Aim

To contribute to a better understanding of how nursing competencies in understanding and addressing spiritual needs, are currently approached in undergraduate nurse education.



Issues in Focus

Spirituality?



Further information and Plans for
Focus group Study.



Appendix 6: Consent form from participants

CONSENT FORM

Title of Research Project:

How is spirituality expressed and addressed in nursing curricula in England?

It is important that you read, understand and sign the consent form. Your contribution to this research is entirely voluntary and you are not obliged in any way to participate, if you require any further details please contact your researcher.

I have been fully informed of the nature and aims of this research

☐

I consent to taking part in it

☐

I understand that I have the right to withdraw from the research at any time without giving any reason

☐

I give permission for my words to be quoted (by use of pseudonym)

☐

I understand that the information collected will be kept in secure conditions for a period of five years at the University of Huddersfield

☐

I understand that no person other than the researcher/s and supervisors will have access to the information provided.

☐

I understand that my identity will be protected by the use of pseudonym in the report and that no written information that could lead to my being identified will be included in any report.

☐

If you are satisfied that you understand the information and are happy to take part in this project please put a tick in the box aligned to each sentence and print and sign below.

Signature of Participant: _____ Print: _____ Date: _____	Signature of Researcher: _____ Print: _____ Date: _____
---	--

(one copy to be retained by Participant / one copy to be retained by Researcher)

UNIVERSITY OF HUDDERSFIELD

TITLE OF PROJECT

How is spirituality expressed and addressed in nursing curricula in England?

NAME OF RESEARCHER

Gulnar Ali

Interview consent form

I have been fully informed of the nature and aims of this research and consent to taking part in it.

I understand that I have the right to withdraw from the interview at any time without giving any reason, and a right to withdraw my data if I wish.

I give my permission/do not give my permission for my interview to be tape recorded.

I give permission to be quoted (by use of pseudonym).

I understand that the tape will be kept in secure conditions at the University of Huddersfield.

I understand that no person other than the interviewer will have access to the recording.

I understand that my identity will be protected by the use of pseudonym in the research report and that no information that could lead to my being identified will be included in any report or publication resulting from this research.

Name of participant

Signature

Date

Name of researcher

Signature

Date

Two copies of this consent form should be completed: One copy to be retained by the participant and one copy to be retained by the researcher

Appendix 7: Question Guide for Interviews

Semi- structured Interview from nursing educators.

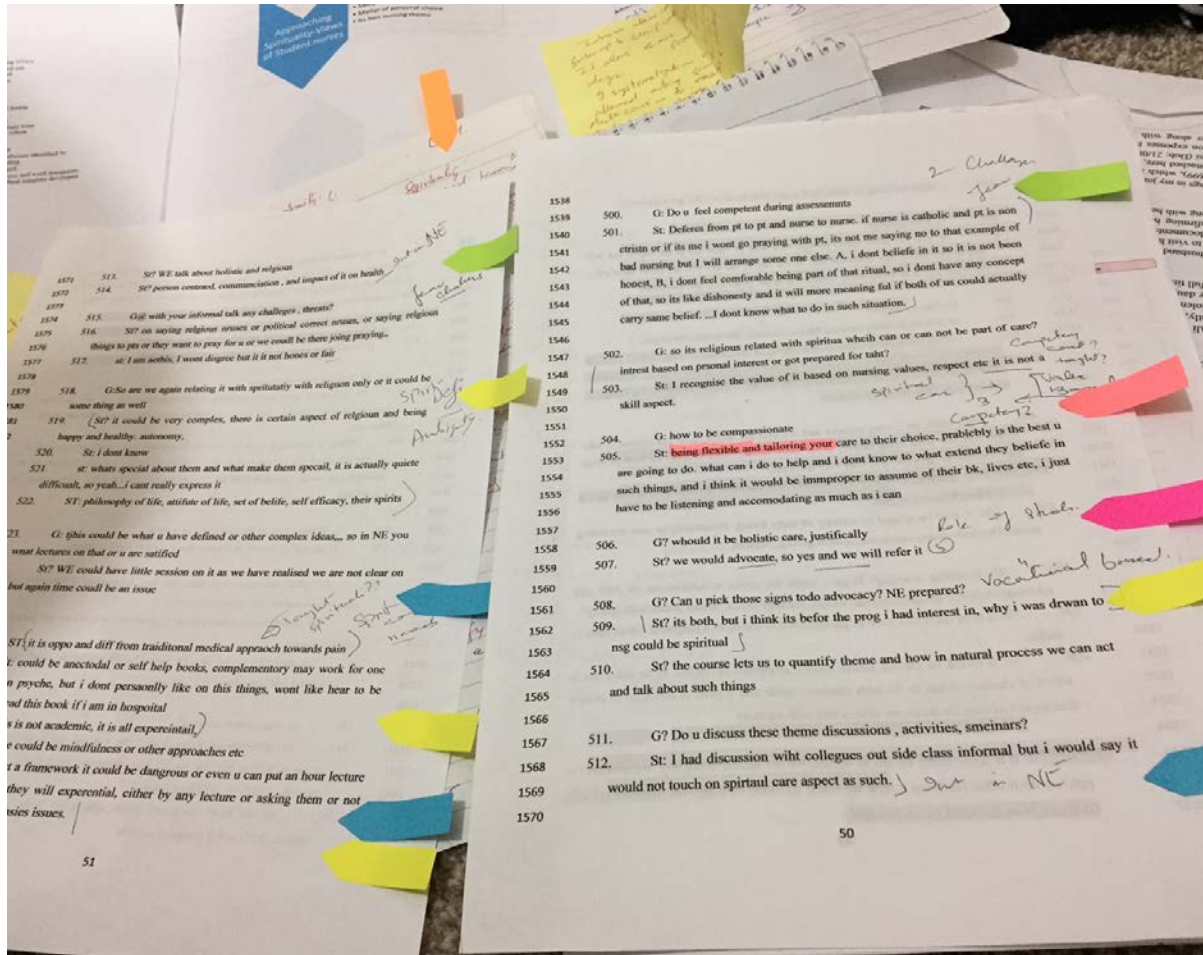
1. How do you approach person-centred and holistic care concepts?
2. Do you relate spiritual care while discussing ideas regarding holistic care?
3. How do you explore spiritual care aspects with your students?
4. Are there any specific strategies to relate spiritual ideas and care aspects?
5. To what extent nursing curriculum allows you to discuss and address spirituality in clinical courses?
6. Are there any potential concerns, or issues that affect relating spirituality in nursing education?
7. What are some of the recommendations you would like to propose to strengthen course content, text books or existing curriculum on spiritual care.

Appendix 8: Interview guide for Focus group study

Interview Questions for Focus group interviews from Student nurses:

1. What do you understand by holistic care?
2. How do you assess person-centred needs?
3. How do you define spirituality?
4. What spirituality means to you?
5. How would you assess your patients for their spiritual care needs?
6. What are some of the teaching and learning strategies you find most effective in understanding spirituality and spiritual care needs?
7. How do you prepare yourself to approach spiritual care aspect of your patients?
8. Do you feel confident and competent enough to address spiritual care needs of your patients?
9. What are some of the challenges you often confront while approaching spiritual care aspects?

Appendix 9: Codes and Themes used to develop template



[illegible]

Appendix 11: Initial template

Theme no.	Main themes	Sub-themes	Parallel themes	Integrative Themes
1.	Concept of Spirituality	<ol style="list-style-type: none"> 1. Identity 2. Self-awareness 3. Near death experiences 4. Dignity 5. Respect 6. Freedom 7. Coping mechanism 8. Belief system 9. Self-actualization 10. Sexuality 11. Caring Presence 12. Compassionate care 13. Concept of God or supernatural 14. Related to Heaven 15. Personal transformation 16. Ambiguous term 17. Fear 	<ol style="list-style-type: none"> 1. Self-awareness 2. Existential needs 3. Religious affiliation 4. Care and compassion 	<ol style="list-style-type: none"> 1. Difficult to be defined 2. Non-explicit theme in nursing education 3. Vocation-based
2.	Concerns and Challenges raised Student nurses	<ol style="list-style-type: none"> 1. Abstract and vague 2. Personal growth 3. Fears and confusion 4. Personal values and beliefs 5. Same as holistic care 6. Matter of personal choice 7. Its non-nursing theme 	<ol style="list-style-type: none"> 1. Spirituality can't be taught 2. Matter of personal Choice 3. Fear 	<ol style="list-style-type: none"> 1. Difficult to be defined 2. Non-explicit theme in nursing education 3. Vocation-based
4.	Concerns and Challenges raised by Nursing educators	<ol style="list-style-type: none"> 1. Personal Competency and confidence level 2. Matter of Choice 3. Fear 4. Creativity 5. Never thought before 6. Not explicit in NMC guides 7. Same as holistic care and person-centred care approach 8. Embedded in nursing philosophy 9. Vocation 	<ol style="list-style-type: none"> 1. Matter of personal choice 2. Non-explicit theme in nursing education 3. Matter of authority and legitimacy 4. Fear 	<ol style="list-style-type: none"> 1. Difficult to be defined 2. Non-explicit theme in nursing education 3. Vocation-based

		10. Value based recruitment		
5.	Representation in Nursing curriculum	<ol style="list-style-type: none"> 1. Same as holistic care 2. Ambiguous 3. Non-explicit 4. Transcultural needs 5. Religion 6. autonomy 	<ol style="list-style-type: none"> 1. Conceptual complexity 2. Spirituality cannot be taught 	<ol style="list-style-type: none"> 1. Difficult to be defined 2. Non-explicit theme in nursing education 3. Vocation-based
6.	Need for Innovation	<ol style="list-style-type: none"> 1. Shared understanding 2. Innovation in teaching 3. Reconstructing curriculum 4. Mindfulness training 5. Value based recruitment 	<ol style="list-style-type: none"> 1. Need clarity on value based teaching and learning 	<ol style="list-style-type: none"> 1. Difficult to be defined 2. Non-explicit theme in nursing education 3. Vocation-based

Appendix 12: Themes corresponding to research finding in literature review

Year	Author	Existing gaps, debates and contributions to integrate spirituality in Nursing education literature 1993- 2016	convergence of ideas and Pattern Matching with the study (Yin 2014)
1993	Narayanasamy	Reported that nurses do acknowledge patient's spiritual needs but find lack in confidence to address spiritual care need.	Question of authority
1994	Ross	Debated on whether formal teaching of spirituality could prepare nurses to deliver quality care or it's the personal trait and morality of each nurse that defines and effects caring behaviour.	Spirituality can/cannot be taught
1997	Bradshaw	Argued whether spirituality can be taught to students or spirituality is personal and vocational?	Spirituality can/cannot be taught
1997	McSherry and Draper	Explored intrinsic and extrinsic socio-political determinants influencing status of nursing in society, which may have greatly impacted in considering spirituality as a legitimate aspect of nursing both in education and practice.	Question of Authority
1999	Bush	Proposed journaling as an effective self-reflection tool to teach concept of spirituality.	Spirituality can/cannot be taught
1999a	Narayanasamy	Identified underlying socio-political and religious influences from Eighteenth and Nineteenth centuries that impacted the integration of spirituality in nursing education.	Question of Authority

1999b	Narayanasamy	Identified the need to develop self-awareness in nursing students for addressing spiritual care need of their patients. Developed ASSET Model to be used in nursing education.	Spirituality can/can't not be taught.
1999	Greenstreet	Argued on differentiating religion from spirituality. Discussed various psychosocial perspectives related with the term spirituality.	Conceptual Complexity
2000	McSherry	Presented critical analysis on historical and traditional teaching approaches that were used to integrate spirituality in nursing education. Suggested nurse education can be complementary in preparing nurses to meet patients' spiritual need.	Question of Authority
2001	Catanzaro and McMullen	Identified the effectivity of using reflective practices in teaching spiritual ideas in nursing.	Spirituality can/cannot be taught.
2002	McSherry, Draper, Kendrick	Determined the effectivity of integrating spirituality in nursing curriculum by using Spirituality and spiritual care rating scale, 17 item Likert scale.	Conceptual complexity. Quest for shared understanding
2002	Hoover	Developed a module on human caring to prepare students, recognising spiritual care needs by using aesthetics.	Spirituality can/cannot be taught.
2003	Pimple, Schmidt, and Tidwell	Found storytelling, use of case studies and role-playing as effective strategies in enhancing self-awareness about spiritual care need.	Spirituality can/cannot be taught. Choice-based
2004	Callister LC, Bond AE, Matsumura G,	Course wise description of integrating spiritual care ideas in nursing was presented.	Quest for a shared understanding.

	Mangum S.		
2005	Kenny & Ashley	Recognised the need of a specialised course for integrating spirituality in paediatric nursing education	Conceptual complexity.
2006	Mitchell, Bennett, and Manfrin-Ledet	Proposed the use of care mapping as an effective teaching learning tool in assessing spiritual care needs of patients.	Choice-based. Spirituality can/cannot not be taught.
2006	Bro'na Mooney a, Fiona Timmins	Proposed innovative approach to integrate ideas related to spirituality and self-awareness through conducting classroom lectures and visit of Art Gallery	Choice-based. Spirituality can/cannot be taught.
2007	Lovanio and Wallace	Emphasised the use of journaling as a reflective tool.	Choice-based. Spirituality can/cannot be taught.
2007	Hood, Olsen and Allen	Explored how nurses learn to be connected through knowledge seeking and caring practices.	Conceptual complexity. Quest for developing a shared understanding
2008	Wallace et al.	Determined the effectiveness of integrating spirituality in nursing curriculum through Spirituality and spiritual care rating scale, 17 item Likert scale	Conceptual complexity. Spirituality can/cannot be taught

2008	McSherry et al.	Explored the ethical basis of teaching student nurses about the concepts of spirituality and spiritual care.	Question of authority. Quest for a shared understanding
2008	Baldacchino	ASSET model applied on Nursing students. A study unit on the spiritual dimension in care was introduced.	Spirituality can/ cannot be taught.
2008	van Leeuwen et al.	The Spiritual Care Competence Scale, (van Leeuwen et al., 2007) was used, to study the effect of a course for nursing students on developing competence in spiritual care.	Spirituality can/cannot be taught. Quest for shared understanding.
2009	Taylor	Virtual teaching modes were introduced to explore spirituality and spiritual care needs of students.	Choice-based. Spirituality can/cannot be taught.
2010	Baldacchino	ASSET model was implemented by developing a comprehensive Study unit covering themes related to spirituality.	Spirituality can/cannot be taught.
2010	Lemmer	One –credit hour course especially designed on transcultural, religious, ethical and psychological foundations for understanding the concept of spirituality.	Spirituality can/cannot be taught.
2011	Nardi, Faan and Rooda	Developed a practice theory of spirituality based nursing to teach integrating metaphysical and	Conceptual complexity Quest for a shared

		spiritual care aspects in nursing care.	understanding
2011	Brass	Emphasised understanding and acknowledging personal religious and spiritual needs based on transcultural ethos to be used in nursing education. T.R.U.S.T.: An Affirming Model for Inclusive Spiritual Care was developed.	Quest for a shared understanding
2012	Cone and Giske	Emphasised on Role modelling of nursing educators to teach and mentor while students develop insights for spirituality and spiritual care need.	Spirituality can/cannot be taught. Quest for a shared understanding.
2012	Giske and Cone	The need to integrate existential and spiritual component more explicit in nursing education was highlighted. Interpersonal relationship between nursing educators and students and between students and patients through enabling spiritual environment were identified.	Conceptual complexity Spirituality can /cannot be taught Question of Authority
2012	Giske	How nursing students learn about spiritual concepts in clinical studies were explored by performing Literature review from 1980-2012	Conceptual complexity Spirituality can/cannot be taught
2013	L.H. Tiew et al.	Spirituality and spiritual care rating scale was used to determine the integration of spirituality in curriculum, and effectiveness of student education. project focusing on spirituality	Spirituality can/cannot be taught

2013	Cooper K, et al.	explored the impact of spiritual care education on nursing students based on Literature review (1993-2011)	Spirituality can/cannot be taught, Quest for developing a shared understanding
2014	Lopez et al.	A cross-sectional survey was conducted - A 32-item WHO-QOL-SRPB questionnaire was used. Study emphasised that nursing students should understand their own spirituality before approaching patients spiritual care aspects.	Spirituality can/cannot be taught
2014	Timmins et al.	Identified that nursing texts should be strengthened by providing consistent focus and inclusion of spiritual care themes	Conceptual complexity Question of authority
2014	Narayanasamy	Highlighted the ambiguity and discrepancies in governmental policies and structural issues overlooking the issues of ethnic plurality with reference to spiritual care needs of NHS patients.	Question of authority Quest for a shared understanding
2014	Yilmaz and Gurler	The study emphasised the need to revise the existing nursing curriculum to integrate spiritual care	Question of authority Quest for a shared understanding
2015	Lewinson et al.,	Identified various scholarship and clinical approaches developed to related spirituality in undergraduate nursing education through Literature review (2002-2014)	Conceptual complexity Quest for a shared understanding
2015	Bennett V. and	Several challenges and barriers in teaching	Conceptual complexity

	Thompson M. L	spirituality in nursing education are recognised.	Quest for a shared understanding
2015	Murphy et al.	Explored how spiritual care content is introduced in the undergraduate children's nursing text books.	Conceptual complexity
2016	Kalkim et al.	Inadequate integration of spirituality in nursing education was reported by nursing students. Time and work constraints along with lack of clarity from nursing educators were identified as major challenges.	Conceptual complexity Question of authority
2016	Caldeira S., et al.	The importance of teaching spirituality was recognised in undergraduate nursing education; however, no standard or established curriculum was found in nursing schools.	Conceptual complexity Question of authority Choice-based.
2016	Strand et al.	Evaluated the strengths of a nursing university and church affiliated hospital partnership intervention; to understand student's learning in spiritual care giving through clinical mentorship.	Question of authority

